Center for Molecular Cancer Diagnostics, INC.

GC/Chlamydia Detection by Gene Amplification *(Ordering Code: NG/CT)*

Support Documents:	Detection of Chlamydia trachomatis and Neisseria gonorrhoeae in Urine, Endocervical, Vaginal and Urethral Specimens
Methodology Name And Description:	Amplification Polymerase Chain Reaction (PCR)
Specimen Requirements:	Testing Volume/Size: 1 mL Type: Gynecological, Urethral, Urine Container: Thin Prep; Transport Temperature: Ambient Notes: One cervical brush in ThinPrep Transport Pap Test Media. Place each specimen in an individually sealed bag.;
Stability	Ambient: Thin prep media: 1 month; Refrigerated: Thin prep media: up to 3 months; Frozen: Thin prep media: 1 years;
Clinical Info:	Rule out infection. The NG/CT PCR test is more sensitive (97-100%) than culture (70-85%), ELISA (60-93%), DFA (85%), or DNA probe (64-93%). Specificity and positive predictive value for PCR are generally over 99%, so false positives are rare. Negative predictive values are also generally over 99%.
Days Performed:	Monday – Friday (CMCD Holidays Excluded)
Reported:	2 Days from receipt of acceptable specimen in lab
Reference Range	NG/CT Amplification - Normal
CPT Code(s):	87491(x1); 87591(x1)

CLIA# 36D2061372
CAP# 7541618

ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087
PHONE: 330-405-2623

Center for Molecular Cancer Diagnostics, INC.

LAB USE ONLY

Received by:

Date Rec'd: | Time Rec'd:

ACCOUNT INFORMATION

Account No. | **Phone No.**

Treating Physician | **UPIN No.**

Requesting Physician Signature

I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record.

Duplicate Report To:

Address:

Fax:

PATIENT INFORMATION

Last Name | **MI**

First Name

Street | **City**

State | **Zip** | **Phone**

Sex: ☐ (M) ☐ (F) | **DOB**

Patient ID No. | **Chart No.**

BILLING INFORMATION

Bill to: Select One

☐ **Medicare** ☐ **Medicaid** ☐ **Patient's Insurance** ☐ **Physician Bill** ☐ **Self Pay** ☐ **Other Insurance**

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Other Dependent**

Primary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

Secondary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

PAP/GYNECOLOGY/OTHER

ICD-9 Code | Volume | ML/CC

Collection: Date | Collection Method: ☐ ThinPrep Only

Test Requested: ☐ PAP ☐ HR HPV ☐ Gonorrhea/Chlamydia ☐ Gonorrhea Only ☐ Chlamydia Only

GYN Source ☐ Cervix ☐ Endocervix ☐ Vaginal ☐ Other

Clinical History LMP/Menopause Date | Last Pap Test Date | History of Abnormal PAP: ☐ Y ☐ N

Results

Additional Information ☐ High Risk Patient ☐ AUB ☐ BCP (Birth Control Pills) ☐ Carcinoma ☐ Chemotherapy/Radiation DX
☐ Hormone Rx ☐ Hysterectomy - Total ☐ Hysterectomy - Subtotal (Cervix Present) ☐ Post Menopause ☐ Post Partum ☐ Pregnancy

PATIENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Patient Signature _____ **Date** _____