

# SACRED HEART EMERGENCY CENTER

9774 Katy Freeway Suite 500  
Houston, Texas 77055  
Tel # 832.358.0200 Fax # 832.358.0202

## Demographic Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**I DO NOT WISH TO BE EVALUATED BY SACRED HEART EMERGENCY  
CENTER**

\_\_\_\_\_  
PRINT NAME OF DONOR DATE

COVID Donor Signature or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*If at any time you feel you need to be seen by a physician, you are more the welcome to check in as a patient at Sacred Heart Emergency Center. No appointment needed. Open 24/7.**

\_\_\_\_\_  
WITNESS DATE



**TEST REQUISITION**  
**NOW TESTING FOR COVID-19**  
**(CORONAVIRUS)**



CLIA #29D2185637 CAP #8793341  
In Partnership with Assurity  
CLIA #29D2066305 COLA #25307

(844) ASK CUUR | FAX: (702) 852-0433 | Lab@CuurDiagnostics.com  
8876 Spanish Ridge Avenue, Suite 203, Las Vegas, NV 89148

**PRACTICE INFORMATION**

Practice Name: Sacred Heart Emergency Center  
Practice Address: 9774 Katy Freeway #500 City: Houston State: Tx Zip: 77055  
Practice Phone: (832) 358-0200 Practice Fax: (832) 358-0202

**PRIMARY PATIENT INFORMATION**

**Med Rec #/Patient Identifier:**

Patient First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Patient Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Country: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_  
Patient Email: \_\_\_\_\_

Patient Gender: ☐ M ☐ F Patient Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

First test for COVID-19? ☐ Y ☐ N ☐ Unknown  
Employed in healthcare? ☐ Y ☐ N ☐ Unknown  
Symptomatic as defined by the CDC? ☐ Y ☐ N ☐ Unknown (if yes, then date of symptom onset (MM/DD/YY): \_\_\_\_\_  
Hospitalized? ☐ Y ☐ N ☐ Unknown  
Intensive Care Unit (ICU)? ☐ Y ☐ N ☐ Unknown

Are you a resident in a congregate care setting? (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting).

☐ Y ☐ N ☐ Unknown  
☐ Y ☐ N ☐ Unknown

**PATIENT INSURANCE INFORMATION**

**IMPORTANT: Please Include Patient Demographic Sheet (Copy of Insurance Card and ID).**

Primary Ins.: \_\_\_\_\_ Group#: \_\_\_\_\_  
Policy#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_ DoB: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_

Secondary Ins.: \_\_\_\_\_  
Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release to **CUUR Diagnostics** of any medical insurance information necessary to process claims for services provided by **CUUR Diagnostics** and its affiliate labs. I hereby authorize **CUUR Diagnostics** to pursue all necessary appeals of full or partial denials of payment in relation to services provided by **CUUR Diagnostics** or its affiliate labs.



Patient Signature: \_\_\_\_\_

**TESTS ORDERED**

**IMPORTANT: Refer to Page (2) for Full List of Panel Targets.**

Collection Date: \_\_\_\_\_ Collection Time: \_\_\_\_\_ Collectors Initials: \_\_\_\_\_

☐ Respiratory Infection Panel



**COVID-19 Screening Test**

☐ Urinary Tract Infection Panel



Other \_\_\_\_\_

**REQUIRED DIAGNOSIS (ICD-10) CODES**

**IMPORTANT: ICD-10 Code Required. Refer to Page (2) for Most Common Codes Per Panel. For Full List Consult the Most Recent ICD-10 Code Book.**

Primary Code: Z20.828 Special Instructions: \_\_\_\_\_  
Secondary Code: \_\_\_\_\_  
Other: \_\_\_\_\_

**Statement of Medical Necessity and Provider Signature**

I attest that I ordered this test for my patient. To a reasonable degree of medical certainty, I believe this test provides necessary information to treat my patient's condition in the most effective manner. I have provided **CUUR Diagnostics** Laboratories my patient's current insurance information and I understand the **CUUR Diagnostics** Corporate Laboratory and its affiliates will be billing the patient's insurance company and accepting assignment on this claim.

Printed Name of Authorizing Provider: \_\_\_\_\_

Signature of Authorizing Provider: \_\_\_\_\_

NPI# of Authorizing Provider: \_\_\_\_\_ Date: \_\_\_\_\_



### RESPIRATORY PANEL

#### TARGET

##### Respiratory Bacteria

Bacteria	Bordetella sp.
Bacteria	B. pertussis
Bacteria	C. pneumoniae
Bacteria	H. influenzae
Bacteria	L. pneumophila
Bacteria	M. pneumoniae
Bacteria	S. aureus
Bacteria	S. pneumoniae

##### Respiratory Virus

Virus	AdV1
Virus	AdV2
Virus	HBV
Virus	Corona229E
Virus	CoronaHKU1
Virus	CoronaNL63
Virus	CoronaOC43
Virus	Human Enterovirus (pan assay)
Virus	Human Enterovirus D68
Virus	HHV3
Virus	HHV4
Virus	HHV5
Virus	HHV6
Virus	hMPV
Virus	HPV1
Virus	HPV2
Virus	HPV3
Virus	HPV4
Virus	RSVA
Virus	RSVB
Virus	RV1
Virus	RV2
Virus	Influenza A
Virus	Influenza A/H1-2009
Virus	Influenza A/H3
Virus	Influenza B

**Coronavirus COVID-19 if "Respiratory Panel with COVID-19" Test Ordered**

#### MOST COMMON ICD-10 CODES

ICD-10	Description	ICD-10	Description
J06.9	Acute upper respiratory infection, unspecified	C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
J16.8	Pneumonia due to other specified infectious organisms	C77	Secondary and unspecified malignant neoplasm of lymph nodes
J18.8	Other pneumonia, unspecified organism	C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
J18.9	Pneumonia, unspecified organism	C78.0	Secondary malignant neoplasm of lung
J20.8	Acute bronchitis due to other specified organisms	D14.3	Benign neoplasm of bronchus and lung
J20.9	Acute bronchitis, unspecified	D14.30	Benign neoplasm of unspecified bronchus and lung
J21.8	Acute bronchiolitis due to other specified organisms	D14.31	Benign neoplasm of right bronchus and lung
J21.9	Acute bronchiolitis, unspecified	D14.32	Benign neoplasm of left bronchus and lung
J22	Unspecified acute lower respiratory infection	D3A.090	Benign carcinoid tumor of the bronchus and lung
J01.90	Acute sinusitis, unspecified	J00	Acute nasopharyngitis [common cold]
J01.91	Acute recurrent sinusitis, unspecified	J01	Acute sinusitis
J01.00	Acute maxillary sinusitis, unspecified	J02	Acute pharyngitis
J01.01	Acute recurrent maxillary sinusitis	J03	Acute tonsillitis
J01.10	Acute frontal sinusitis, unspecified	J04.0	Acute laryngitis
J01.11	Acute recurrent frontal sinusitis	J04.1	Acute tracheitis
J01.20	Acute ethmoidal sinusitis, unspecified	J05.1	Acute epiglottitis
J01.21	Acute recurrent ethmoidal sinusitis	J06	Acute upper respiratory infections of multiple and unspecified sites
J01.30	Acute sphenoidal sinusitis, unspecified	J06.0	Acute laryngopharyngitis
J01.31	Acute recurrent sphenoidal sinusitis	J67	Hypersensitivity pneumonitis due to organic dust
J01.40	Acute pansinusitis, unspecified	J67.0	Farmer's lung
J01.41	Acute recurrent pansinusitis	J67.8	Hypersensitivity pneumonitis due to other organic dusts
J01.80	Other acute sinusitis	J67.9	Hypersensitivity pneumonitis due to unspecified organic dust
J01.81	Other acute recurrent sinusitis	R06	Abnormalities of breathing
J15.9	Unspecified bacterial pneumonia	R97	Abnormal tumor markers
J18.1	Lobar pneumonia, unspecified organism	Z85	Personal history of malignant neoplasm
J18.2	Hypostatic pneumonia, unspecified organism	Z85.1	Personal history of malignant neoplasm of trachea, bronchus and lung
C34	Malignant neoplasm of bronchus and lung	Z85.11	Personal history of malignant neoplasm of bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung	Z85.9	Personal history of malignant neoplasm, unspecified
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung		



### URINARY TRACT INFECTION PANEL

#### TARGETS

##### UTI Gram Positive Bacteria

Bacteria	E. faecalis
Bacteria	E. faecium
Bacteria	S. saprophyticus
Bacteria	S. agalactiae

##### UTI Gram Negative Bacteria

Bacteria	A. baumannii
Bacteria	C. freundii
Bacteria	E. aerogenes
Bacteria	E. cloacae
Bacteria	E. coli
Bacteria	K. oxytoca
Bacteria	K. pneumoniae
Bacteria	M. morganii
Bacteria	P. mirabilis
Bacteria	P. vulgaris
Bacteria	P. stuartii
Bacteria	P. aeruginosa

##### UTI Fungal

Yeast	C. albicans
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#### MOST COMMON ICD-10 CODES

ICD-10	Description	ICD-10	Description
N39.0	Urinary tract infection, site not specified	N34	Urethritis and urethral syndrome
N30.00	Acute cystitis without hematuria	N34.1	Nonspecific urethritis
N30.01	Acute cystitis with hematuria	N34.2	Other urethritis
N30.90	Cystitis, unspecified without hematuria	N34.3	Urethral syndrome, unspecified
N30.91	Cystitis, unspecified with hematuria	N36	Other disorders of urethra
R82.81	Pyuria	N37	Urethral disorders in diseases classified elsewhere
N30.20	Other chronic cystitis without hematuria	N39	Other disorders of urinary system
N30.21	Other chronic cystitis with hematuria	N39.4	Other specified urinary incontinence
N30.80	Other cystitis without hematuria	N39.41	Urge incontinence
N30.81	Other cystitis with hematuria	N39.498	Other specified urinary incontinence
A56.2	Chlamydial infection of genitourinary tract, unspecified	N39.9	Disorder of urinary system, unspecified
A64	Unspecified sexually transmitted disease	O23	Infections of genitourinary tract in pregnancy
I12	Hypertensive chronic kidney disease	O23.0	Infections of kidney in pregnancy
I13	Hypertensive heart and chronic kidney disease	O23.1	Infections of bladder in pregnancy
M02.3	Reiter's disease	O23.2	Infections of urethra in pregnancy
N10	Acute pyelonephritis	O23.4	Unspecified infection of urinary tract in pregnancy
N13	Obstructive and reflux uropathy	O23.51	Infection of cervix in pregnancy
N18	Chronic kidney disease (CKD)	O86.2	Urinary tract infection following delivery
N18.9	Chronic kidney disease, unspecified	P39.3	Neonatal urinary tract infection
N23	Unspecified renal colic	R10.2	Pelvic and perineal pain
N26.9	Renal sclerosis, unspecified	R30.0	Dysuria
N30	Cystitis	R77	Other abnormalities of plasma proteins
N30.0	Acute cystitis	R78.81	Bacteremia
N30.1	Interstitial cystitis (chronic)	R82	Other and unspecified abnormal findings in urine
N30.10	Interstitial cystitis (chronic) without hematuria	R94.4	Abnormal results of kidney function studies
N30.11	Interstitial cystitis (chronic) with hematuria	Z87.440	Personal history of urinary (tract) infections
N30.2	Other chronic cystitis		



2817 Miller Ranch Rd. Ste. 317, Pearland, TX 77584  
Phone: (281) 240-0974 Fax: 1-844-604-0145

CLIA # 45D2111506

Director's Name: **Dr. Yan Zou, PhD, TC(NRCC), C(ASCP).**

## Respiratory Health

Corona Virus Testing

# CVT 1001

Clinic Name: Sacred Heart Emergency  
Address: 9774 Katy Fwy #500 Houston Tx  
Phone: 832-358-0200 Fax: 832-358-0202 T1055

ALL THE HEADERS IN RED 1, 2 & 6 MUST BE FILLED

<b>1 Patient Information</b>	
Last Name _____	
First Name _____	MI _____
Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
SSN _____	Tel _____
Address _____	
City _____	State _____ Zip _____

<b>5 Specimen Processor</b>
Date: ____ / ____ / ____ Time: ____ : ____ AM PM
Collector's Name _____

<b>6 Patient Signature</b>	
X _____ Date: ____ / ____ / ____	
<i>I authorize APC Health to analyze the specimen provided by me and report the results of such analysis to the ordering Physician in conformance with his/her order. (further explanation on back)</i>	

<b>2 Insurance</b>	
<b>Attached Copy of Insurance Card &amp; Demographic Sheet</b>	
Insurance Type :	Medicare Medicaid Commercial Self-Pay
Policy Holder name _____	
Policy # _____	DOB (MM/DD/YYYY) _____
Relationship to patient :	Self Spouse Parents

<b>7 Authorized Provider Signature</b>
Print Name _____
Signature _____ Date: ____ / ____ / ____

<b>8 Physician Medical Necessity Notice</b>	
<i>Physicians and other authorized persons are required to only order medically necessary tests supported by an ICD-10 diagnosis from the patient's medical record.</i>	

<b>3 Respiratory Panel</b>	
<input type="checkbox"/> <b>Viral Targets</b>	<input type="checkbox"/> <b>Bacterial Targets</b>
<input type="checkbox"/> Adenovirus	<input type="checkbox"/> Bordetella Pertussis
<input type="checkbox"/> Coronavirus HKU1	<input type="checkbox"/> Bordetella Parapertussis
<input type="checkbox"/> Coronavirus NL63	<input type="checkbox"/> Chlamydia Pneumoniae
<input type="checkbox"/> Coronavirus 229E	<input type="checkbox"/> Mycoplasma Pneumoniae
<input type="checkbox"/> Coronavirus OC43	<input type="checkbox"/> _____
<input checked="" type="checkbox"/> Coronavirus COVID-19	<input type="checkbox"/> _____
<input type="checkbox"/> Human Metapneumovirus	<input type="checkbox"/> _____
<input type="checkbox"/> Human Rhinovirus/Enterovirus	<input type="checkbox"/> _____
<input type="checkbox"/> Influenza A	<input type="checkbox"/> _____
<input type="checkbox"/> Influenza A/H1	<input type="checkbox"/> _____
<input type="checkbox"/> Influenza A/H3	<input type="checkbox"/> _____
<input type="checkbox"/> Influenza A/H1-2009	<input type="checkbox"/> _____
<input type="checkbox"/> Influenza B	<input type="checkbox"/> _____
<input type="checkbox"/> Parainfluenza virus 1	<input type="checkbox"/> _____
<input type="checkbox"/> Parainfluenza virus 2	<input type="checkbox"/> _____
<input type="checkbox"/> Parainfluenza virus 3	<input type="checkbox"/> _____
<input type="checkbox"/> Parainfluenza virus 4	<input type="checkbox"/> _____
<input type="checkbox"/> Respiratory Syncytial Virus	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

<b>4 Additional Comments/Testing Requests</b>
_____ _____ _____ _____

<b>9 Diagnosis Codes</b>
<u>Z20.82</u> _____ _____ _____

↓ PEEL HERE ↓

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Date of Collection: \_\_\_\_\_ Collectors Initials: \_\_\_\_\_

# CVT 1001

Please fill out this sticker area and place on sample cup.

04





Dascena Laboratory  
COVID-19 Testing  
13831 Northwest Frwy, Suite 435,  
Houston, TX 77040

## Requisition Form

### Patient Information

Patient Name (Last) (First) Date Of Birth

Referring Facility MRN

Sex

OO

M F

Patient's Phone Number

( )

Patient Address City State Zip Code

Patient Race

### BILL TO:

☐ PPO ☐ HMO ☐ Client ☐ Medicare ☐ Outpatient ☐ Inpatient

Insurance Info: Attach a copy of front & back of Insurance card or facesheet.  
Technical (lab) and professional (M.D.) charges are billed separately.

### Requesting Facility

Facility Name & Address

Sacred Heart Emergency Center  
9774 Katy Freeway #500  
Houston TX 77055

Phone No.

Fax No.

832-358-0200

832-358-0202

(Name & Address, Fax & Phone)

COPIES TO:

### TESTING & SAMPLE INFORMATION:



COVID-19 Molecular PCR Test (LABSARSCOV2-1)

### SOURCE & TYPE:

- ☒ Nasopharyngeal Swab  
☐ Oropharyngeal Swab  
☐ Other \_\_\_\_\_

Sample Collection Date

Time

### PCR SAMPLE COLLECTION & HANDLING GUIDELINES

- Use nasal swabs
- Other swabs are acceptable\* EXCEPTIONS: Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing
- Place swab immediately into tube containing 2-3 ml of viral transport media (preferred), universal transport media, or buffered saline.\*

For Lab Use Only

REQUIRED INFORMATION ICD Code(s) -

Z20.828

### Requesting Physician

Physician Name

Physician NPI #:

Submitter ID:

M.D. Phone No (for reporting positive results)

Fax No (for reporting all results)

Physician Signature - REQUIRED

Date & Time

### SPECIMEN DELIVERY

Dascena Laboratory  
13831 Northwest Frwy, Suite 435,  
Houston, TX 77040

