

Bill to Submitter/Client
(Submitting Facility is Responsible for Payment)



Children's Hospital Colorado

Children's Hospital Colorado
Department of Pathology & Laboratory Medicine
Microbiology Lab Requisition
Phone (720) 777-6711
Fax (720) 777-7118

Specimen Shipping Address:
Children's Hospital Colorado
Clinical Laboratory - Room B0200
13123 E. 16th Ave
Aurora, CO 80045

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS				
***PLEASE PROVIDE COMPLETE BILLING INFORMATION**				
Contact Information				
Submitting Institution Name (Submitter)	Submitting Institution Address Street City, State, Zip Phone Result Fax			
Client Specimen Label (if available)	Internal Specimen Label			
Patient Information				
Last Name	First Name	Middle I	Birthdate (MM/DD/YYYY)	Sex
Ordering Provider (Last, First, and Middle Initial)	Ordering Provider Phone	ICD10/Diagnosis	Ordering Provider NPI	
Microbiology Specimen Information				
Date Collected (MM/DD/YY) _____	<input type="checkbox"/> Serum	<input type="checkbox"/> Nasal Wash	<input type="checkbox"/> Other	
Time Collected (HHMM) _____ AM / PM	<input type="checkbox"/> Plasma	<input type="checkbox"/> BAL	Infection and/or Organism Expected:	
	<input type="checkbox"/> Stool	<input type="checkbox"/> Swab Source & Site:		
	<input type="checkbox"/> Urine			
FAILURE TO COMPLETE WILL DELAY RESULTS				
Bill To: <input type="checkbox"/> Billing Facility and Address same as Submitter Listed				
Billing Contact Information: Name: Email: Phone:		Billing Facility and Address are DIFFERENT than Submitter Listed, Bill To: Institution Name: Address (incl City, State, Zip): Phone: Fax:		
Additional comments regarding specimen or testing requested:				
****If below items are not included WITH the specimen, the referring provider will be billed directly and responsible for payment****				
A face and or demographic sheet with the following criteria MUST be provided: <ul style="list-style-type: none"> - Patients Full Name - Patients Full Address (City, State and Zip) - Patients Phone - Patients Insurance Name AND Plan Type (Primary AND Secondary) - Policy/ID Number - If subscriber is different than patient a DOB is REQUIRED 				
Microbiology Lab Test Information - Ordering laboratory is responsible for accuracy of test selection				
<input type="checkbox"/> Adenovirus PCR Qual (LAB6342)	<input type="checkbox"/> CMV PCR Quant (LAB7321)	<input type="checkbox"/> GI Path Panel (LAB6958)	<input type="checkbox"/> MEP Panel PCR (LAB7329)	
<input type="checkbox"/> Adenovirus PCR Quant (LAB7431)	<input type="checkbox"/> CT and NG PCR (LAB7166)	<input type="checkbox"/> GI Path Panel with no Diff (LAB8434)	<input type="checkbox"/> MRSA PCR (LAB7591)	
<input type="checkbox"/> BK Virus PCR Quant (LAB9584)	<input type="checkbox"/> EBV PCR Quant (LAB7322)	<input type="checkbox"/> HHV6 PCR Quant (LAB7430)	<input type="checkbox"/> Respiratory Path Panel (LAB5595)	
<input type="checkbox"/> C. difficile Toxin B PCR (LAB5736)	<input type="checkbox"/> Enterovirus PCR Qual (LAB4299)	<input type="checkbox"/> HSV PCR (LAB5891)	<input type="checkbox"/> SARS CoV-2 (LAB9100)	
<input type="checkbox"/> CF Path Culture - Throat (LAB4093)	<input type="checkbox"/> Enterovirus & Parechovirus Multiplex PCR (LAB10040)		<input type="checkbox"/> VZV PCR (LAB6621)	

By submitting this requisition you agree to the standard terms and agreements of Children's Hospital Colorado, to obtain a copy of these please reach out to LabClientServices@childrenscolorado.org

Please visit our website (www.childrenscolorado.org/labrequisitions) regularly to obtain our most current requisition.