KARIUS clarity at speed® | TEST

Test Requisition Form

Required information

Test Requested: Karius Test™
Tissue Type: Plasma

PATIENT INFORMATION

MRN #	Last Name	First Name	M.I.
Date of Birth (mm/dd/yyyy)	Biological Sex ☐ Female ☐ Male		

ORDERING PHYSICIAN INFORMATION

Last Name	First Name	M.I.	Phone (xxx-xxx-xxxx)
Ordering Physican NPI	Email (name@email.com)		

SPECIMEN INFORMATION

Date Collected	Time Collected	Specimen ID #	Specimen Type ☐ Plasma-PPT tube (preferred) ☐ K2-EDTA Plasma

CLINICAL CONTEXT

Primary ICD-10 Code	Secondary ICD-10 Code

Immunocompromised

- ☐ Bone Marrow Transplant
  - ☐ GVHD
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Solid Tumor
- ☐ Solid Organ Transplant
  - ☐ Kidney ☐ Liver
  - ☐ Heart ☐ Lung
  - ☐ Visceral ☐ Pancreas
- ☐ HIV
- ☐ Steroids/Biologics
- ☐ Primary Immunodeficiency/ Genetic

Respiratory/ENT

- ☐ Covid-19 Co-infection
- ☐ Pneumonia/LRTI
- ☐ Empyema
- ☐ Cavitary Lesion
- ☐ Nodule
- ☐ URI
- ☐ Sinusitis
- ☐ Pharyngitis

Musculoskeletal/SST

- ☐ Arthritis
- ☐ Osteomyelitis
- ☐ Myositis
- ☐ Spinal Infection
- ☐ Lymphadenitis/ Lymphadenopathy
- ☐ Cellulitis

Hardware

- ☐ Central Line
- ☐ CV Device
- ☐ Ventricular Shunt
- ☐ Orthopedic Hardward
- ☐ Baclofen Pump
- ☐ ETT/Tracheostomy
- ☐ Dialysis
- ☐ ECMO

General

- ☐ Sepsis
- ☐ Fever
- ☐ FUO
- ☐ Neutropenia
- ☐ Malaise
- ☐ Myalgia/Arthralgia

Systemic Treatment

- ☐ Antibacterials
- ☐ Antivirals
- ☐ Antifungals
- ☐ Antiparasitics

Gastrointestinal

- ☐ Liver Abscess
- ☐ Splenic Abscess
- ☐ Enteritis/Colitis
- ☐ Cholangitis

Cardiovascular

- ☐ Endocarditis
- ☐ Pericarditis
- ☐ Aortitis

Central Nervous System

- ☐ Meningitis
- ☐ Brain/Epidural/Subdural Abscess

INSTITUTION INFORMATION

Institution		Phone (xxx-xxx-xxxx)
Address		City
State	Zip code	

I attest that I ordered the Karius Test, or am authorized to order the test by the ordering physician as documented in the patient record. This test provides medically necessary needed to treat the patient's condition in the more effective manner. I have informed the patient that Karius (California) may use or disclose the de-identified results for future unspecified research.

Authorized Clinician Signature _____ Date _____

REMEMBER! Ship it via FedEx
Shipping class: First Overnight