Diagnostic
Pathology
Medical
Group, Inc.

Additional Testing
Authorization Form for Molecular Testing

Submit this form to order additional testing on the Aptima swab.

Additional testing may be ordered up to 30 days from the collection date.

I authorize Diagnostic Pathology Medical Group, Inc. (DPMG) to perform the following test(s) on my patient:

☐ Chlamydia ☐ Gonorrhea ☐ Mycoplasma Genitalium

☐ Trichomonas ☐ Vaginitis Panel

Patient's Name: _____

Patient's Insurance: _____

Date of Birth: _____ Accession Number: _____

Physician's Name: _____ Phone Number: _____

It is the responsibility of the ordering physician to obtain prior authorization for this service if required as part of the patient's healthcare coverage. By my signature below, I acknowledge that DPMG is not financially responsible for payment of the additional tests ordered.

Physician's Signature: _____ Date: _____

IF CONFIRMATION OF ORDER IS REQUIRED PLEASE INCLUDE YOUR FAX NUMBER FOR A FAX BACK: _____

Please fax this form to (916) 446-9330

Order Received: Date:_____ Time:_____ Initials:_____

If you have any questions please feel free to contact Customer Service at (916) 446-0424
3301 C Street, #200-E, Sacramento, California 95816