DSL Lab Test Instructions for the GI Map 1 day Stool Test

What you should receive when your test kit arrives:
1. A box with a Sample collection container.
2. Pre-paid FedEx envelope.

What you need to do to complete the DNA Stool Test:
1. Please Print and fill out the Correct Requisition Form.
2. This requisition form is for patients that have paid the full cash price not the lab read fee, check your invoice from the office if you are unsure off this.
3. Be sure to include the date the sample was taken.
4. There is no need to avoid any nutrient supplements or medications to prepare for this test.
5**. You MUST include the completed requisition form with your stool sample.**
6. If the requisition form isn't sent in with the kit, your kit will be discarded, and you will have to repeat the test.

What you need to do next:
1. Dr Justin will go over your lab results with you at your next appointment.
2. Make sure you have an appointment scheduled with Dr. Justin to review the results.
3. Results typically take 8-10 days, and you can request a copy at the start of your consult.

Zonulin is an add-on to the GI-MAP which will cost an additional charge of $99.

- If you would like to add the Zonulin marker, please email us at office@justinhealth.com and we will invoice you for the $99 add-on fee.
- In the "Test Information" field of the Requisition Form below (page 4), manually put a check mark in the box beside "Zonulin add-on to GI-MAP".

For any questions not addressed on this sheet, please contact the lab directly at 877-485-5336

Stool Collection Instructions

Please review all instructions and collection kit components before starting your sample collection. Please avoid taking aspirin for two days prior to collecting sample. DO NOT discontinue taking prescription medications unless directed by your physician.

Kit components

- Cardboard Kit box
- Test Request form
- 1- Collection tray
- 1- Yellow capped vial
- 1- Zip lock Specimen bag
- 2- Gloves
- 1- Absorbent material
- 1- FedEx Clinical Pak mailer

If you are missing any of the needed components or have questions about the collection please call the Diagnostic Solutions Lab Customer Services department at 877-485-5336.

**Avoid contact with skin and eyes to the specimen vial fluid. If you do get fluid in your eyes, flush eyes with water for 15 minutes. If your skin comes in contact wash with soap and water. If ingested please contact a physician.

Collection instructions

Step 1 – Please write the patients name and date of birth on the yellow capped vial.

Step 2 – If possible void urine prior to collecting stool. Collect stool by passing stool onto Collection tray.

Step 3 – Using the spoon attached to the cap of the yellow vial, spoon stool from different areas of the sample into the vial. Fill vial to the red fill line. Just over half full.

Step 4 – Carefully mix stool and fluid with the spoon. Replace cap tightly and shake vial vigorously for 30 seconds.

Step 5 – Place Yellow cap vial into ziplock specimen bag along with absorbent pad. Seal the bag. Place the specimen bag with the sample vial into the kit box.

Step 6 - Fill out the ***Test Request Form*** completely. Be sure to write the date of sample collection in the Patient section of the form. Payment type must be completed with payment included to process sample. Place Test Request Form into the box with the sample.

**If you cannot ship the specimen on the day of collection please refrigerate the sample by placing the box containing the sample into the refrigerator.

Shipping Instructions

Before shipping be sure that the Yellow cap vial and the Test Request Form are labeled and completely filled out including payment. Be sure the sample vial sealed in the ziplock bag and that the Test Request Form are in the Kit box.

Locate the FedEx Clinical Pak mailer. Fill in your name and address on the shipping label attached to the outside of mailer.

Place kit box into FedEx Clinical Pak. Remove strip to reveal sticky film and press both sides of mailer together to seal the pouch.

Call FedEx to schedule a pick-up. Dial 1-800-238-5355. When the automated greeting begins say **"Rep".** When asked if you are shipping a package say **"Yes".** A live person will then answer to help schedule your pickup. Let them know you are shipping using a ***Billable Stamp***.

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Fax: 470-239-5017
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Lab Use Only

Practice Information

Just in Health
912 S Capital of Texas Hwy #170
Austin, TX 78746
512-535-1817

Billing Type

(Please attach copies of all insurance cards, front and back, to Test Request Form)

- ☐ Medicare
- ☐ Patient Cash (No insurance will be billed)
- ☐ Bill to Patient Insurance (Deposit must be included with sample)
- ☑ Bill Clinician **(Patient Paid Doctor)**

Ordering Clinician

Acct # 1054 NPI # 1477828408

Name: Dr. Justin Marchegiani Degree: D.C.

Signature: Justin Marchegiani

For professional billing please initial: JM

Patient Information

Patient Name: ______

Patient DOB: __/__/____ (MM/DD/YYYY)

Sex: ☐ Female ☐ Male

Responsible Party Name: ______

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Guardian

Address of patient or responsible party:

Street: ______

City: ______ State: ______ Zip: ______

Phone Number: ______

Email: ______

Test Information

Date Sample Collected: __/__/____ (MM/DD/YYYY)

- ☑ **GI-MAP** (Includes GI Pathogens and H. pylori)
- ☐ **GI Pathogens**
- ☐ **H. Pylori** ☐ ***Stool*** ☐ ***Biopsy***
- ☐ **Zonulin (only)**
- ☐ **Zonulin add-on to GI-MAP**
- ☐ **CytoDX**
- ☐ **Calprotectin**
- ☐ **GenomicInsight**
- ☐ **GenomicInsight - Data Only**

Reflex test based on results:

- ☐ **Antibiotic Resistance Genes**

Insurance/Medicare

Primary Insurance: **N/A**

Name of Insured: ______

Policy/Medicare Number: ______

Group Number: ______

Secondary Insurance: ______

Name of Insured: ______

Policy/Medicare Number: ______

Group Number: ______

Patient or Responsible Party Signature:

X______ Date: ______

By signing I understand that my insurance will be billed and I will be responsible for all charges not paid by my insurance.

ICD Coding

In the space below provide ICD codes that apply to signs, symptoms and findings for this visit.

N/A **K59.9**

Credit Card Payment Authorization

Credit Card Type: ☐ VISA ☐ Master Card ☐ AmEx

Card # **N/A**

Exp Date: ______ CCRV# ______

Name on Card: ______

Signature: ______

By signing this section, you are authorizing Diagnostic Solutions Laboratory, LLC to charge your card for the payment type selected.