# CYSTINURIA MANAGEMENT PROGRAM ENROLLMENT FORM
## 24-HOUR CYSTINE URINE TEST REQUEST

### Patient information

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | GENDER (M/F)

STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE # (OPTIONAL) | MOBILE PHONE # (OPTIONAL)

EMAIL

CURRENTLY ON THIOL-BINDING MEDICATION: ☐ YES ☐ NO

IF YES, WHICH MEDICATION? ______

**ALL PATIENT INFORMATION ABOVE MUST BE COMPLETED.**

### Practitioner information

LAST NAME | FIRST NAME

FACILITY NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

OFFICE/PRACTITIONER PHONE # | FAX #

PRACTITIONER NPI # | OFFICE CONTACT NAME

PRACTITIONER EMAIL

**ALL PRACTITIONER INFORMATION ABOVE MUST BE COMPLETED.**

### Order

**Diagnosis:** ☐ E72.01 CYSTINURIA ☐ OTHER ______

**Diagnosis in ICD-CM format in effect at date of service (highest specificity required)**

**24-hour cystine urine panels** *(for patients with known cystinuria)*:

| TESTS | | | EGL CODES | |
|---|---|---|---|---|
| pH | Urea nitrogen | Timed collection | TEST CODE: BCYSQ | EGL ACCOUNT NUMBER: 44 |
| Phosphorus | Sodium | Quantitative cystine | | |

**ALL TESTS WILL BE PERFORMED ON EACH 24-HOUR URINE COLLECTION.**

TEST FREQUENCY INSTRUCTIONS:

SEND TEST TO PATIENT EVERY: ☐ 3 MONTHS* ☐ 4 MONTHS* ☐ 6 MONTHS* ☐ 12 MONTHS*

*In a 12-month period.

For questions regarding this program, contact the Cystinuria Management Program at:

1-855-846-5390, M-F: 8:00 AM-8:00 PM (ET)

**FAX THIS COMPLETED FORM TO 1-844-889-2577.**

All faxed orders will be processed next business day.

### Criteria for free testing:

Patient has been diagnosed with cystinuria.

I hereby attest that the patient has been diagnosed with cystinuria and is a candidate for this 24-Hour Cystine Urine Test. I understand that the diagnostic testing services offered under this program are directional in nature and that they do not eliminate the need for additional medical management.

Authorized practitioner signature ______ Date ______

Program may be cancelled or changed at any time.

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