ELITE CLINICAL LABORATORY

OHIO RIVER LABORATORIES

Address: 3600 South Gessner Rd
STE 110, Houston, TX 77063
CLIA – 45D1061571
Lab Director - Albert Chen M.D.
Phone: 281-378-2116
Fax: 281-466-2483

Please attach the following documents with this test order

- ☐ Medical Records
- ☐ Copy of Patient Insurance ID Card
- ☐ Medication List, If any

NAIL FUNGAL AND PARONYCHIAL TESTING REQUISITION FORM

PATIENT INFORMATION

Patient First Name	Patient Last Name	Biological Sex ☐ F ☐ M

Date of Birth (MM/DD/YYYY)	Phone Number	Email	Social Security Number

Address	City	State	Zip

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

PATIENT INSURANCE INFORMATION

☐ Insurance ☐ Self-Pay ☐ Client Bill

Name of the insurance	Secondary Insurance, If any
Insurance Policy/ID number	Name of the insured
Insurance Group number	Date of Birth of Insured

SPECIMEN AND PRACTICE INFORMATION

Speciment Type: ☐ **Nail Clipping** ☐ **Paronychial Tissue**

Site: Toe - ☐Left ☐Right **Finger** - ☐Left ☐Right

Collection date and time:.....

PRACTICE INFORMATION

Provider Name:.....

Practice/Facility Name: .....

Address:.....

City, State, Zip: .....

Phone:.....Fax:.....

TEST PANEL

Nail/Paronychia

Bacterial/Viral
Bacteroides fragilis, vulgatus
Enterobacter aerogenes, cloacae
Enterococcus faecalis, faecium
Escherichia coli
Klebsiella pneumoniae, oxytoca
Peptostreptococcus anaerobius, asaccharolyticus, magnus, prevotii
Proteus mirabilis, vulgaris
Pseudomonas aeruginosa
Serratia marcescens
Staphylococcus aureus
Staphylococcus spp.
Streptococcus agalactiae
Streptococcus pyogenes

Fungal
Aspergillus flavus, fumigatus, niger, terreus
Blastomyces dermatidis
Candida albicans, glabrata, parapsilosis, tropicalis
Candida auris
Epidermophyton floccosum
Fusarium oxysporum, solani
Malassezia furfur, restricta, sympodialis, globosa
Microsporum audouinii, canis, gypseum
Trichophyton mentagraphophytes/ i nterdigitale, rubrum,
soudanense, terrestre, tonsurans,
verrucosum, violaceum
Trichosporon mucoides, asahii

Antibiotic Resistance

VanA, VanB
ermB, C; mefA
SHV, KPC Groups
dfr (A1, A5), sul (1, 2)
mecA
qnrA1, qnrA2, qnrB2
tet B, tet M
IMP, NDM, VIM Groups
ACT, MIR, FOX, ACC Groups
OXA-48,-5113
CTX-M1 (15), M2 (2), M9 (9), M8/25 Groups

ICD-10 CODES

☐	B35.0	TINEA BARBAE AND TINEA CAPITIS	☐	L60.2	ONYCHOGRYPHOSIS	☐	B36.9	SUPERFICIAL MYCOSIS
☐	B35.2	TINEA MANUUM	☐	L60.8	OTHER NAIL DISORDERS	☐	L03.03	CELLULITIS OF TOE
☐	B35.4	TINEA CORPORIS	☐	B35.1	TINEA UNGUIUM	☐	L60.1	ONYCHOLYSIS
☐	B35.6	TINEA CRURIS	☐	B35.3	TINEA PEDIS	☐	L60.3	NAIL DYSTROPHY
☐	B35.9	DERMATOPHYTOSIS	☐	B35.5	TINEA IMBRICATA	☐	L60.5	YELLOW NAIL SYNDROME
☐	L03.01	CELLULITIS OF FINGER	☐	B35.8	OTHER DERMATOPHYTOSES	☐	L60.9	NAIL DISORDER
☐	L60.0	INGROWING NAIL						

Additional ICD10 codes:

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Patient Signature

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to **Elite Clinical Laboratory** its assigned affiliates and authorized representatives for laboratory services furnished to me by **Elite Clinical Laboratory** I irrevocably designate, authorize and appoint **Elite Clinical Laboratory** or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to **Elite Clinical Laboratory** immediately upon receipt. I hereby authorize **Elite Clinical Laboratory** its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to **Elite Clinical Laboratory**, in compliance with federal and state laws. **Elite Clinical Laboratory**, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of **Elite Clinical Laboratory** and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Patient or Patient Representative / Relationship to Patient

Date:

ORDERING PHYSICIAN SIGN HERE

Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient

I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder and that the results will be used in medical management and care decisions for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. I agree to provide the Care Plan notes and Letter of Intent for this order if the insurance requests the lab to gather the medical necessity for any reason

Ordering Physician Signature

Date: