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

WOUND CARE TESTING REQUISITION FORM

PATIENT INFORMATION

Patient First Name		Patient Last Name		Biological Sex <input type="checkbox"/> F <input type="checkbox"/> 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

SPECIMEN AND PRACTICE INFORMATION

<input type="checkbox"/> Insurance <input type="checkbox"/> Self-Pay <input type="checkbox"/> Client Bill		Specimen Type: <input type="checkbox"/> E-swab Wound(s) Site(s):.....	
Name of the insurance		Collection date and time:.....	
Secondary Insurance, If any		PRACTICE INFORMATION	
Insurance Policy/ID number		Provider Name:.....	
Name of the insured		Practice/Facility Name:	
Insurance Group number		Address:.....	
Date of Birth of Insured		City, State, Zip:	
		Phone:.....Fax:.....	

TEST PANEL

Wound

Bacteria

Acinetobacter baumannii
 Actinomyces israelii
 Bacteroides fragilis
 Bartonella henselae
 Citrobacter freundii
 Clostridium perfringens, Clostridium septicum
 Corynebacterium striatum
 Enterobacter aerogenes, Enterobacter cloacae
 Enterococcus faecalis, Enterococcus faecium
 Escherichia coli
 Finegoldia magna
 Francisella tularensis
 Fusobacterium necrophorum,
 Fusobacterium nucleatum
 Klebsiella oxytoca, Klebsiella pneumoniae
 Malassezia furfur

Morganella morganii
 Mycobacterium kansasii, Mycobacterium
 intracellulare
 Nocardia asteroides
 Pasteurella multocida
 Peptoniphilus harei, Peptoniphilus ivorii
 Peptostreptococcus SPP
 Proteus mirabilis, Proteus vulgaris
 Providencia stuartii
 Pseudomonas aeruginosa
 Staphylococci Coag-Neg (epidermidis,
 haemolyticus,lugdunensis)
 Staphylococcus aureus
 Streptococcus pneumoniae
 Streptococcus pyogenes (Group A)

Antibiotic Resistance

Carbapenemase and
 Metallo-Betalactamase Resistance
 Class A and C Beta-lactams Resistance
 Class A and Plasmid ESBL Resistance
 Class C Beta-lactams Resistance
 Class D Betalactamase Resistance
 Dihydrofolate and Sulfonamide
 Resistance
 Macrolide Resistance
 Methicillin Resistance
 Quinolone Resistance
 Tetracycline Resistance
 Vancomycin Resistance

ICD-10 CODES

- | | |
|---|--|
| <input type="checkbox"/> A54.00 Gonococcal infection of lower genitourinary tract, unspecified
<input type="checkbox"/> A54.01 Gonococcal cystitis and urethritis, unspecified
<input type="checkbox"/> A54.02 Gonococcal vulvovaginitis, unspecified
<input type="checkbox"/> A54.03 Gonococcal cervicitis, unspecified
<input type="checkbox"/> A54.09 Other gonococcal infection of lower genitourinary tract
<input type="checkbox"/> A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
<input type="checkbox"/> A54.21 Gonococcal infection of kidney and ureter
<input type="checkbox"/> A54.22 Gonococcal prostatitis
<input type="checkbox"/> A54.23 Gonococcal infection of other male genital organs
<input type="checkbox"/> A54.24 Gonococcal female pelvic inflammatory disease
<input type="checkbox"/> A54.29 Other gonococcal genitourinary infections
<input type="checkbox"/> A54.30 Gonococcal infection of eye, unspecified
<input type="checkbox"/> A54.31 Gonococcal conjunctivitis
<input type="checkbox"/> A54.32 Gonococcal iridocyclitis
<input type="checkbox"/> A54.33 Gonococcal keratitis | <input type="checkbox"/> A54.6 Gonococcal infection of anus and rectum
<input type="checkbox"/> A54.81 Gonococcal meningitis
<input type="checkbox"/> A54.82 Gonococcal brain abscess
<input type="checkbox"/> A54.83 Gonococcal heart infection
<input type="checkbox"/> A54.84 Gonococcal pneumonia
<input type="checkbox"/> A54.85 Gonococcal peritonitis
<input type="checkbox"/> A54.86 Gonococcal sepsis
<input type="checkbox"/> A54.89 Other gonococcal infections
<input type="checkbox"/> A54.9 Gonococcal infection, unspecified
<input type="checkbox"/> A55 Chlamydial lymphogranuloma (venereum)
<input type="checkbox"/> A56.00 Chlamydial infection of lower genitourinary tract, unspecified
<input type="checkbox"/> A56.01 Chlamydial cystitis and urethritis
<input type="checkbox"/> A56.02 Chlamydial vulvovaginitis
<input type="checkbox"/> A56.09 Other chlamydial infection of lower genitourinary tract
<input type="checkbox"/> A56.11 Chlamydial female pelvic inflammatory disease
<input type="checkbox"/> A56.19 Other chlamydial genitourinary infection |
|---|--|

ICD-10 CODES

- | | |
|---|---|
| <input type="checkbox"/> A54.39 Other gonococcal eye infection | <input type="checkbox"/> A56.2 Chlamydial infection of genitourinary tract, unspecified |
| <input type="checkbox"/> A54.40 Gonococcal infection of musculoskeletal system, unspecified | <input type="checkbox"/> A56.3 Chlamydial infection of anus and rectum |
| <input type="checkbox"/> A54.41 Gonococcal spondylopathy | <input type="checkbox"/> A56.4 Chlamydial infection of pharynx |
| <input type="checkbox"/> A54.42 Gonococcal arthritis | <input type="checkbox"/> A56.8 Sexually transmitted chlamydial infection of other sites |
| <input type="checkbox"/> A54.43 Gonococcal osteomyelitis | <input type="checkbox"/> A59.00 Urogenital trichomoniasis, unspecified |
| <input type="checkbox"/> A54.49 Gonococcal infection of other musculoskeletal tissue | <input type="checkbox"/> A59.01 Trichomonal vulvovaginitis |
| <input type="checkbox"/> A54.5 Gonococcal pharyngitis | <input type="checkbox"/> A59.02 Trichomonal prostatitis |
| <input type="checkbox"/> A59.03 Trichomonal cystitis and urethritis | <input type="checkbox"/> H10.021 Other mucopurulent conjunctivitis, left eye |
| <input type="checkbox"/> A59.09 Other urogenital trichomoniasis | <input type="checkbox"/> H10.022 Other mucopurulent conjunctivitis, bilateral |
| <input type="checkbox"/> A59.8 Trichomoniasis of other sites | <input type="checkbox"/> H10.023 Other mucopurulent conjunctivitis, unspecified eye |
| <input type="checkbox"/> A59.9 Trichomoniasis, unspecified | <input type="checkbox"/> H10.029 Unspecified acute conjunctivitis, unspecified eye |
| <input type="checkbox"/> A71.0 Initial stage of trachoma | <input type="checkbox"/> H10.30 Unspecified acute conjunctivitis, right eye |
| <input type="checkbox"/> A71.1 Active stage of trachoma | <input type="checkbox"/> H10.31 Unspecified acute conjunctivitis, left eye |
| <input type="checkbox"/> A71.9 Trachoma, unspecified | <input type="checkbox"/> H10.32 Unspecified acute conjunctivitis, bilateral |
| <input type="checkbox"/> A74.0 Chlamydial conjunctivitis | <input type="checkbox"/> H10.33 Unspecified chronic conjunctivitis, right eye |
| <input type="checkbox"/> B30.9 Viral conjunctivitis, unspecified | <input type="checkbox"/> H10.401 Unspecified chronic conjunctivitis, left eye |
| <input type="checkbox"/> B37.3 Candidiasis of vulva and vagina | <input type="checkbox"/> H10.402 Unspecified chronic conjunctivitis, bilateral |
| <input type="checkbox"/> B37.41 Candidal cystitis and urethritis | <input type="checkbox"/> H10.403 Unspecified chronic conjunctivitis, unspecified eye |
| <input type="checkbox"/> B37.42 Candidal balanitis | <input type="checkbox"/> H10.409 Simple chronic conjunctivitis, bilateral |
| <input type="checkbox"/> B37.49 Other urogenital candidiasis | <input type="checkbox"/> H10.421 Simple chronic conjunctivitis, right eye |
| <input type="checkbox"/> D70.0 Congenital agranulocytosis | <input type="checkbox"/> H10.422 Simple chronic conjunctivitis, left eye |
| <input type="checkbox"/> D70.1 Agranulocytosis secondary to cancer chemotherapy | <input type="checkbox"/> H10.423 Simple chronic conjunctivitis, bilateral |
| <input type="checkbox"/> D70.2 Other drug-induced agranulocytosis | <input type="checkbox"/> H10.429 Simple chronic conjunctivitis, unspecified eye |
| <input type="checkbox"/> D70.3 Neutropenia due to infection | <input type="checkbox"/> H10.431 Chronic follicular conjunctivitis, right eye |
| <input type="checkbox"/> D70.4 Cyclic neutropenia | <input type="checkbox"/> H10.432 Chronic follicular conjunctivitis, left eye |
| <input type="checkbox"/> D70.8 Other neutropenia | <input type="checkbox"/> H10.433 Chronic follicular conjunctivitis, bilateral |
| <input type="checkbox"/> D70.9 Neutropenia, unspecified | <input type="checkbox"/> H10.439 Chronic follicular conjunctivitis, unspecified eye |
| <input type="checkbox"/> D72.825 Bandemia | <input type="checkbox"/> I88.1 Chronic lymphadenitis, except mesenteric |
| <input type="checkbox"/> D72.89 Other specified disorders of white blood cells | <input type="checkbox"/> L04.0 Acute lymphadenitis of face, head and neck |
| <input type="checkbox"/> D73.81 Neutropenic splenomegaly | <input type="checkbox"/> L04.1 Acute lymphadenitis of trunk |
| <input type="checkbox"/> D75.81 Myelofibrosis | <input type="checkbox"/> L04.2 Acute lymphadenitis of upper limb |
| <input type="checkbox"/> H10.011 Acute follicular conjunctivitis, right eye | <input type="checkbox"/> L04.3 Acute lymphadenitis of lower limb |
| <input type="checkbox"/> H10.012 Acute follicular conjunctivitis, left eye | <input type="checkbox"/> L04.8 Acute lymphadenitis of other sites |
| <input type="checkbox"/> H10.013 Acute follicular conjunctivitis, bilateral | <input type="checkbox"/> L04.9 Acute lymphadenitis, unspecified |
| <input type="checkbox"/> H10.019 Other mucopurulent conjunctivitis, right eye | |

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: