

WoundDX TEST REQUISITION

CLIENT INFORMATION *(Please check requesting physician)*

PATIENT INFORMATION *(Green highlighted sections are required information)*

Please attach patient face sheet and front and back of primary and secondary insurance card: PATIENT NAME REQUIRED
 See Attached

Name (Last, First): _____
Date of Birth: ___/___/___ Sex: M F SS# _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Work Phone #: _____
Medical Record #: _____

BILLING INFORMATION

Primary: Medicare Medicaid Insurance Patient Client
Insurance: _____ Policy #: _____ Group #: _____
Ins. Address: _____ City: _____ State: _____ Zip: _____
Policy Holder: _____ DOB: _____
Policy Holder: Self Spouse Child Other
Secondary: Medicare Medicaid Insurance Patient Client
Insurance: _____ Policy #: _____ Group #: _____
Ins. Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize the release to EmeritusDX/Freedom of any medical and insurance information necessary to process claims for services provided by EmeritusDX/Freedom. I hereby authorize EmeritusDX/Freedom to pursue all necessary appeals of full or partial denials of payment in relation to services provided by EmeritusDX/Freedom.

Patient Signature

CLINICAL INFORMATION

Collection Date: _____ Clinical History: _____

PHYSICIAN NOTICE Physician is required to (1) submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity, or (2) explain and have the patient sign an ABN.

ICD-10 CODES Physician is required to submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity.

- | | |
|---|--|
| <input type="checkbox"/> T81.31XA Disruption of external operation (surgical) wound, initial | <input type="checkbox"/> A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site |
| <input type="checkbox"/> T81.31XD Disruption of external op wound, not elsewhere classified, subsequent | <input type="checkbox"/> A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site |
| <input type="checkbox"/> T81.30XA Disruption of wound, unspecified, initial | <input type="checkbox"/> A49.08 Other bacterial infections of unspecified site |
| <input type="checkbox"/> T81.30XD Disruption of wound, unspecified, subsequent encounter | <input type="checkbox"/> B95.1 Streptococcus, group B, as the cause of diseases classified elsewhere |
| <input type="checkbox"/> T81.4XXA Infection following a procedure, initial | <input type="checkbox"/> B95.2 Enterococcus as the cause of diseases classified elsewhere |
| <input type="checkbox"/> T81.4XXD Infection following a procedure, subsequent encounter | <input type="checkbox"/> B95.8 Unspecified staphylococcus as the cause of diseases classified elsewhere |
| <input type="checkbox"/> L02.91 Cutaneous abscess, unspecified | <input type="checkbox"/> B96.4 Proteus (mirabilis) (morganii) as the cause of diseases classified elsewhere |
| <input type="checkbox"/> L08.9 Local infection of the skin and subcutaneous tissue | <input type="checkbox"/> B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified elsewhere |
| <input type="checkbox"/> R89.5 Ab microbiological findings in other organs, systems and tissues | <input type="checkbox"/> B96.20 Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere |
| <input type="checkbox"/> S31.30XA Unspecified open wound of scrotum and testes, initial encounter | <input type="checkbox"/> B96.29 Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere |
| <input type="checkbox"/> S31.30XD Unspecified open wound of scrotum and testes, subsequent encounter | <input type="checkbox"/> Other(s): _____ |

WoundDX TEST

WoundDX, collected via eSwab

Site:
1) _____ 3) _____
2) _____ 4) _____

IS PATIENT ON ANTIBIOTICS? YES NO

KNOWN ALLERGIES: _____

WoundDX PANEL

- | | | | | | | |
|----------------------------|------------------------|----------------------------|-------------------------|------------------------|-----------------------------|-------------------------|
| - ACINETOBACTER BAUMANNII | - CANDIDA ALBICANS | - COAGULASE NEGATIVE STAPH | - ENTEROCOCCUS FAECIUM | - MYCOPLASMA HOMINIS | - PSEUDOMONAS AERUGINOSA | - VIRIDIANS GROUP STREP |
| - ACTINOBACULUM SCHAALI | - CANDIDA GLABRATA | - CORYNEBACTERIUM RIEGELII | - ESCHERICHIA COLI | - PANTOEAE AGGLOMERANS | - SERRATIA MARCESCENS | |
| - AEROCOCCUS URINAE | - CANDIDA PARAPSILOSIS | - ENTEROBACTER AEROGENES | - KLEBSIELLA OXYTOCA | - PROTEUS MIRABILIS | - STAPHYLOCOCCUS AUREUS | |
| - ALLOSCARDOVIA OMNICOLENS | - CITROBACTER FREUNDII | - ENTEROBACTER CLOACAE | - KLEBSIELLA PNEUMONIAE | - PROTEUS VULGARIS | - STAPHYLOCOCCUS AGALACTIAE | |
| - CANDIDA ALBICANS | - CITROBACTER KOSERI | - ENTEROCOCCUS FAECALIS | - MORGANELLA MORGANII | - PROVIDENCIA STUARTII | - UREAPLASMA UREALYTICUM | |

GENOTYPE ANTIBIOTIC RESISTANCE GENES

• AMPICILLIN • CARBAPENEM • EXTENDED SPECTRUM BETA-LACTAMASE • METHICILLIN • QUINOLINONE/FLUOROQUINOLONE • VANCOMYCIN

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature _____ Date _____ / _____ / _____
Signature required on this order or in the patient's medical record

Name: _____	Name: _____	Name: _____	Name: _____
DOB: _____	DOB: _____	DOB: _____	DOB: _____
Site 1: _____	Site 2: _____	Site 3: _____	Site 4: _____

Please make a copy of this document for your records.