CORE BIO LABS
Precise • Comprehensive • Reliable

WOUND NAIL TEST REQUISITION

INTERNAL USE ONLY

Receiving Date:
Receiving Time:

ACCOUNT INFORMATION

Client:	**Site:**	**Ordering Provider:**	
Site Contact:	**Email:**	**Phone Number:**	**NPI:**

PATIENT DEMOGRAPHICS

Collection Date: / /	**Collection Time:**	**AM/PM:** ☐ AM ☐ PM		
Last Name:	**First Name:**	**Phone Number:**		
Street Address:	**City:**	**State:**	**Zip Codes:**	**State County:**
Date of Birth: / /	**Gender:** ☐ Male ☐ Female	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Undefined		

Race: ☐ Black ☐ White ☐ Mixed Race ☐ American Indian/Native Alaskan ☐ Hispanic/Latino ☐ Hawaiian/Pacific Island ☐ Asian ☐ Other/Unknown

Medication allergy:

(ABR*) - Antibiotic Resistance Genes **(AST*) -** Antibiotic Sensitivity Test

☐ WOUND PCR PANEL ☐ WOUND PCR PANEL WITH ABR ☐ CULTURE WITH AST* ☐ VIRAL (HSV1-3)

Sample Type: ☐ **Wound Swab** (Eswab Kit)

Location: 1. 2.

☐ ACINETOBACTER BAUMANNII	☐ CANDIDA TROPICALIS	☐ ENTEROCOCCUS FAECIUM	☐ NEOFUSICOCCUM MANGIFERAE	☐ STAPHYLOCOCCUS SAPROPHYTICUS
☐ ACREMONIUM STRICTUM	☐ CITROBACTER FREUNDII	☐ EPIDERMOPHYTON FLOCCOSUM	☐ PREVOTELLA LOESCHEII	☐ STREPTOCOCCUS AGALACTIAE (GROUP B)
☐ ASPERGILLUS FUMIGATUS	☐ CLOSTRIDIUM NOVYI (A,B)	☐ ESCHERICHIA COLI	☐ PROTEUS MIRABILIS	☐ STREPTOCOCCUS DYSGALACTIAE (GROUP G)
☐ ASPERGILLUS NIGER	☐ CLOSTRIDIUM PERFRIGENS	☐ FUSARIUM SOLANI	☐ PROTEUS VULGARIS	☐ STREPTOCOCCUS PYOGENES (GROUP A)
☐ ASPERGILLUS VERSICOLOR	☐ CLOSTRIDIUM SEPTICIUM	☐ KINGELLA KINGAE	☐ PSEUDOMONAS AERUGINOSA	☐ STREPTOCOCCUS PNEUMONIAE
☐ BACTEROIDES FRAGILIS	☐ CORYNEBACTERIUM SP	☐ KLEBSIELLA OXYTOCA	☐ SCOPULARIOPSIS BREVICAULIS	☐ TRICHOPHYTON INTERDIGITALE
☐ CANDIDA ALBICANS	☐ CUTIBACTERIUM (PROPIONIBACTERIUM) ACNES	☐ KLEBSIELLA PNEUMONIA	☐ SERRATIA MARCESCENS	☐ TRICHOPHYTON RUBRUM
☐ CANDIDA GLABRATA	☐ ENTEROBACTER AEROGENES	☐ MICROSPORUM AUDOUINII	☐ STAPHYLOCOCCUS AUREUS	☐ **ANTIBIOTIC RESISTANCE GENES***
☐ CANDIDA KRUSEI	☐ ENTEROBACTER CLOACAE	☐ MORGANELLA MORGANII	☐ STAPHYLOCOCCUS COAGULASE-NEGATIVE	
☐ CANDIDA PARAPSILOSIS	☐ ENTEROCOCCUS FAECALIS	☐ MORAXELLA CATARRHALIS	☐ STAOHYLOCOCCUS EPIDERMIDIS	

Viral Panel: ☐ HERPES SIMPLEX VIRUS 1 ☐ HERPES SIMPLEX VIRUS 2 ☐ HUMAN HERPESVIRUS 3

☐ NAIL PCR PANEL ☐ NAIL PCR PANEL WITH ABR *

Location: 1. 2.

GRAM POSITIVE:
☐ STAPHYLOCOCCUS AUREUS

GRAM NEGATIVE:
☐ PSEUDOMONAS AERUGINOSA

FUNGI:

☐ ACREMONIUM STRICTUM	☐ CANDIDA KRUSEI	☐ NEOFUSICOCCUM MANGIFERAE
☐ ASPERGILLUS FUMIGATUS	☐ CANDIDA PARAPSILOSIS	☐ SCOPULARIOPSIS BREVICAULIS
☐ ASPERGILLUS NIGER	☐ CANDIDA TROPICALIS	☐ TRICHOPHYTON INTERDIGITALE
☐ ASPERGILLUS VERSICOLOR	☐ EPIDERMOPHYTON FLOCCOSUM	☐ TRICHOPHYTON RUBRUM
☐ CANDIDA ALBICANS	☐ FUSARIUM SOLANI	
☐ CANDIDA GLABRATA	☐ MICROSPORUM AUDOUINII	

ANTIBIOTIC RESITANCE GENES*

☐ CARBAPENEMS	☐ QUINOLONE	☐ VANCOMYCIN
☐ ESBL	☐ SULFONAMIDE/ TRIMETHOPRIM	☐ AMPC
☐ FOSFOMYCIN	☐ TETRACYCLINE	☐ METHICILLIN
☐ MACROLIDE		

ICD 10 Codes: _____ _____ _____ _____ _____ _____

BILLING INFORMATION

Insurance Company:	Group Number:	Policy Number:	☐ **Self-Pay**
Name of Insured:	Relationship to Insured:	DOB of Insured: / /	☐ **Client Direct (Facility Pay)**

AUTHORIZING SIGNATURES

Patient Request: I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Print Patient Name:	Print Signature:	Date:

Physician Certification: I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Authorizing Name:	Provider Authorizing Signature:	Date:

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