bach diagnostics
passion, science, care

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CLIA # 05D2101629

1. PRACTICE NAME:

ADDRESS:

PHONE:

PROVIDER: *(Circle only the patient's provider)*

2. PATIENT INFORMATION

LAST NAME: **FIRST NAME:** **MIDDLE NAME:**

SEX: ☐ Male ☐ Female

DOB:

SSN:

ADDRESS:

Street Address City State Zip Code

PHONE NUMBER:

INSURANCE TYPE: ☐Medi-Cal ☐Medicare ☐PPO ☐Other: _____

Health Network Name Member ID Number Group Number

3.SPECIMEN INTAKE INFO

COLLECTOR'S NAME:

DATE COLLECTED:

TIME COLLECTED:

4. DIAGNOSIS CODE

- ☐ **L60.9** – Nail disorder, unspecified
- ☐ **B35.1** – Tinea unguium
- ☐ **L98.7** – Excessive and redundant skin & subcutaneous tissue
- ☐ **E11.621** – Type 2 Diabetes mellitus with foot ulcer
- ☐ **L89.893** – Pressure ulcer of other site, stage 3
- ☐ **L89.894** – Pressure ulcer of other site, stage 4
- ☐ **S81.802** – Unspecified open wound, left lower leg, initial encounter
- ☐ **S81.801A** – Unspecified open wound, right lower leg, initial encounter
- ☐ Other: _____ _____

5. NAIL (Select option A or B)

☐ A) MYCOTIC NAIL DEBRIDEMENT

Clinical Features of the Nail (Select at least one clinical feature that applies below):

☐ Hypertrophy/thickening ☐ Discoloration ☐ Lysis ☐ Loosening of the nail ☐ Brittleness ☐ Other:_____

Medical Necessity (Required):

☐ Required to differentiate fungal disease from psoriatic nails, tumor, or other nail pathology
☐ Required as a definitive treatment for a prolonged period of time is being planned involving the use of a prescription medication which could pose health issues

☐ B) SURGICAL BIOPSY OF THE NAIL *(Select at least one clinical indication that applies below):*

☐ Severe or recurrent fungal nail infection that has failed to respond to usual, less invasive treatment
☐ Symptomatic onychocryptosis
☐ Subungual abscess and/or hematoma
☐ Subungual and/or periungual tumors
☐ Onychogryphosis or onychauxis
☐ Diagnosis of suspected lichen planus or psoriasis of fingernail or toenail
☐ Congenital nail dystrophies that jeopardize integrity of the finger or toe

Specimen #1 (circle)	Nail Unit 1 (Fungi/Neoplasm/Psoriasis) - *Dry bag*	Specimen #2 (circle)	Nail Unit 2 (Fungi/Neoplasm/Psoriasis) - *Dry bag*
Left 1 2 3 4 5	☐Comprehensive Nail Analysis (PCR, PAS & H&E)	**Left** 1 2 3 4 5	☐Comprehensive Nail Analysis (PCR, PAS & H&E)
Right 1 2 3 4 5	☐Onychomycosis Histopathology only (PAS & H&E)	**Right** 1 2 3 4 5	☐Onychomycosis Histopathology only (PAS & H&E)

6. BIOPSY

SPECIMEN #1 ☐ Left ☐ Right

☐ Biopsy ☐ Debridement
☐ Excision ☐ Aspiration (fresh)
☐ PCR Swab ☐ Other: _____

Wound - *eSwab*

☐ PCR, Wound, Fungal, Bacteria
☐ Resistance Genes
☐ Other: _____

Skin - *Formalin*

☐ **Pigmented lesion** (R/O Melanoma)
☐ **Non-pigmented lesion** (Verruca/ R/O Melanoma)
☐ **Dermatitis** (Eczematous/Tinea) - w/ PAS Stain
☐ **Ulceration** (Malignancy/Vasculitis)
☐ Other: _____

Soft Tissue - *Formalin*

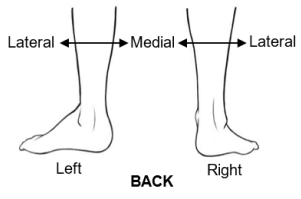
☐ Tumor (Ganglion/Lipoma/Sarcoma) Inflammatory
☐ (Tophus/Abscess)
☐ Other: _____

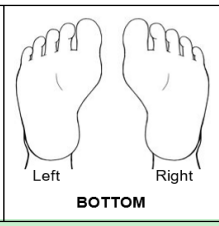
Joint Fluid

☐ Crystal Analysis (Gout) - *(Alcohol / ThinPrep Soln)*
☐ Cytology (Neoplasm) - *(Alcohol / ThinPrep Soln)*
☐ Culture & Sensitivity (Infection) - *(eSwab)*

Specimen Site (circle and label below)

Location: _____





History/Other Clinical Information

SPECIMEN #2 ☐ Left ☐ Right

☐ Biopsy ☐ Debridement
☐ Excision ☐ Aspiration (fresh)
☐ PCR Swab ☐ Other: _____

Wound - *eSwab*

☐ PCR, Wound, Fungal, Bacteria
☐ Resistance Genes
☐ Other: _____

Skin - *Formalin*

☐ **Pigmented lesion** (R/O Melanoma)
☐ **Non-pigmented lesion** (Verruca/ R/O Melanoma)
☐ **Dermatitis** (Eczematous/Tinea) - w/ PAS Stain
☐ **Ulceration** (Malignancy/Vasculitis)
☐ Other: _____

Soft Tissue - *Formalin*

☐ Tumor (Ganglion/Lipoma/Sarcoma)
☐ Inflammatory (Tophus/Abscess)
☐ Other: _____

Joint Fluid

☐ Crystal Analysis (Gout) - *(Alcohol / ThinPrep Soln)*
☐ Cytology (Neoplasm) - *(Alcohol / ThinPrep Soln)*
☐ Culture & Sensitivity (Infection) - *(eSwab)*

7. AUTHORIZATIONS (Provider's signature must be present in order for test to be processed.)

I acknowledge that the laboratory has my permission to release my results directly to the treating physician or facility. I hereby authorize my insurance benefits to be paid directly to the laboratory for services rendered and I agree to endorse any payments received from my insurer and forward them directly to the laboratory for services rendered. By signing this authorization, I allow the release of any medical information necessary to process this claim. I, the undersigned, understand that I am responsible for all co-pays and deductibles.

Patient Signature _____ **Date** _____

The ordering physician or his/her authorized representative must sign his/her name and indicate the date the test is ordered. The signature constitutes a certification that, with respect to tests reimbursed by Medicare or other third party payers, the testing is medically necessary and the results will be used in the management of the patient.

Provider OR Representative Signature _____ **Date** _____

Name: Name: Name: Name:

DOB: DOB: DOB: DOB:

REQUIRED: Attach patient face sheet, as well as front and back copies of current insurance card(s).