bach diagnostics
passion, science, care

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CLIA # 05D2101629

1. PRACTICE INFORMATION

Org Name
Address
Phone & Fax

Please mark the doctor below:

- ☐ Dr.
- ☐ Dr.
- ☐ Dr.

2. PATIENT INFORMATION (Please complete all highlighted fields.)

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. PANEL SELECTION (Please select one or more panels below.)

☐ SURGICAL PATHOLOGY

Sample Type:	Specimen Site:	Gross Description:	Diagnosis Description:
☐ Biopsy ☐ Excision ☐ Shave ☐ Aspirate/Crystal Analysis ☐ Debridement ☐ Other: _____			

☐ WOUND

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

Specimen Site:

Wound Diagnosis Code:

- ☐ **L98.7** – Excessive and redundant skin and 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
- ☐ **L03.116** – Cellulitis of left lower limb
- ☐ **L03.115** – Cellulitis of right lower limb
- ☐ **S81.801A** – Unsp. open wound, right lower leg, initial encounter
- ☐ **S81.802A** – Unsp. open wound, left lower leg, initial encounter
- ☐ **S31.105S** – Unsp. open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, sequela
- ☐ **T81.31XA** – Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
- ☐ **Other:** _____

☐ RESPIRATORY

- ☐ Respiratory PCR (Viral, Bacterial)
- ☐ COVID PCR (SARS-CoV-2)
  - ☐ Reflex to respiratory panel if negative for SARS-CoV-2

Specimen Site:

Respiratory Diagnosis Code:

- ☐ **J06.9** – Acute Upper Respiratory Infection of Unsp. Site
- ☐ **R06.00** – Dyspnea, Unsp.
- ☐ **R05.00** – Cough
- ☐ **J01.90** – Acute Sinusitus, Unsp.
- ☐ **J00** – Acute Nasopharyngitis
- ☐ **J32.9** – Unsp. Sinusitus, Chronic
- ☐ **R06.02** – Shortness of Breath
- ☐ **Other:** _____

☐ URINARY TRACT INFECTIONS

- ☐ Urinalysis (UA)
  - ☐ **Reflex to fungal & bacterial PCR with resistance genes** if UA is positive for one of the following: bacteria, nitrite, leukocyte esterase, white blood cell (>5/HPF)

Specimen Site:

Urinary Diagnosis Code:

- ☐ **N30.1** – Interstitial cystitis (chronic)
- ☐ **N30.0** – Acute cystitis
- ☐ **R30.0** – Dysuria
- ☐ **R30.9** – Painful micturition, unsp.
- ☐ **R35.0** – Frequency of micturition
- ☐ **R39.15** – Urgency of urination
- ☐ **R39.9** – Unspecified symptoms and signs involving the genitourinary system
- ☐ **Other:**_____

5. AUTHORIZATIONS

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.

Physician/ 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).