WOUNDREQUISITION FORM

SUREDx
a division of Suretox laboratory

Practice Information

1.PATIENT INFORMATION

Last Name _____

First NameMI _____ _____

Sex: ☐ F ☐M DOB // Resides: ☐Home ☐Facility

Name of Facility: ☐N/A _____

Address: _____

City, State, ZIP: _____

Facility Contact Person: _____

Facility Contact Phone: _____

2.PAYMENT INFORMATION

BILL: ☐ Patient ☐ Insurance ☐ Other

☐See attached copy of patient demographics/insurance info

Primary Insured Name:

Relationship to insured: ☐Self ☐Spouse ☐Child ☐ Other

Insurance Company: _____

Member ID# _____ Group ID# _____

City, State, ZIP: _____

☐No Fault, Workers Comp Claim # _____

Adjuster Name: _____ Phone# _____

Date of Injury __/__/____ Body Part: _____

3.SPECIMEN COLLECTION

Date of Collection: _____ Time: _____ ☐AM ☐PM

Collected by: _____

TYPE:Wound (Swab)/Location Swabbed _____

4.DIAGNOSTIC INFORMATION

ICD-10 CODES:

- ☐ **A48.8**: Other specified bacterial disease
- ☐ **R59.0**: Enlarged lymph nodes, unspecified
- ☐ **M25.50**: Joint pain unspecified
- ☐ **R53.1**: Weakness
- ☐ **M79.1**: Myalgia
- ☐ **40.1**: Stupor
- ☐ **R50.9**: Fever
- ☐ **R63.0**: Anorexia
- ☐ **R53.81**: Other malaise
- ☐ **Z22.330**: Carrier of Group B Streptococcus
- ☐ **A49.9**: Bacterial Infection unspecified
- ☐ **B99.9**: Unspecified infectious disease
- ☐ **R51**: Headache
- ☐ **R57.9**: Shock
- ☐ **R59.0**: Enlarged lymph nodes, unspecified
- ☐ **Z20.89**: Suspected exposure to other communicable disease

5.PATHOGENS TESTED

Aerobic Bacteria, Gram-Positive: Enterococcus faecalis, Enterococcusfaecium,Mycobacteroidesabscessus,Mycobacterium chelonae,Staphylococcus aureus,Klebsiella oxycota,Klebsiella pneumonia,Staphylococcus epidermidis, Staphylococcus

Aerobic Bacteria,Gram-Negative: Acinetobacter baumannii, Citrobacter freundii, Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli,Proteusmirabilis, Proteus vulgaris,Pseudomonas aeruginosa.

Aerobic Bacteria,Gram-Negative: Acinetobacter baumannii, Citrobacter freundii Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli,Proteus mirabilis, Proteus vulgaris,Pseudomonas aeruginosa.

Anaerobic Bacteria, Gram-Positive: Clostridium perfringens,Clostridiumsepticum.

Anaerobic Bacteria, Gram-Negative: Bacteroides fragilis,Prevotella intermedia, Prevotellaoralis.

Fungi: Aspergillus flavus,Aspergillus fumigates, Aspergillus niger, Candida albicans, Candida glabrata, Candida parapsilosis,Candida tropicalis, Candida

6. PATIENT AUTHORISATION

I authorize Suretox to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Suretox for services I received. I understand that Suretox may be an out-of-network provider with my insurer. I also understand that in sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Suretox immediately. Failure to send payment with 30 days of receipt could result in my account

Patient Signature: _____ _____

7. PHYSICIAN SIGNATURE

I authorize the above ordered test(s)

Provider Signature: _____ _____

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