bach diagnostics
passion, science, care

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1. PRACTICE INFORMATION: Name, Address, Phone Number

2. PATIENT INFORMATION

LAST NAME: FIRST: MI:

Sex: ☐ Male ☐ Female DOB: SSN:

PATIENT ADDRESS & PHONE: ☐ See Attached

3.SPECIMEN INTAKE DETAILS

COLLECTOR'S NAME:

DATE COLLECTED: TIME COLLECTED:

☐Medical ☐ Medicare ☐PPO ☐Other:____________

4. DIAGNOSIS CODE

L98.7 Unspecified disorder of skin · E11.621 Type 2 Diabetes mellitus with foot ulcer · L03.116 Cellulitis of left lower limb · L03.115 Cellulitis of right lower limb · Other: ____________

B35.1 Onychomycosis · L60.9 Unspecified nail disorder · L89.893 Pressure ulcer of outer site, stage 3 · L89.894 Pressure ulcer of other site, stage 4 · S81.801A Unsp. open wound, right lower leg · S81.802A Unsp open wound, left lower leg

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.

☐ Signature on File

Physician/ Representative Signature: ________________________________ Date: ____

5. MEDICAL NECESSITY-CLINICAL FEATURES OF NAIL

☐ Onycholysis ☐ Discoloration ☐ Odor ☐ Brittleness ☐ Paronychia ☐ Other: _________

MEDICAL NECESSITY FOR NAIL PLATE BIOPSY

☐ Unresponsive to Current Therapy ☐ Questionable Etioloy ☐ Other: ___________

6. CLINICAL INFORMATION

SPECIMEN # 1 ☐ Left ☐ Right

☐ Biopsy
☐ Excision
☐ Aspiration/Crystal Analysis (fresh or in ETOH)
☐ PCR Swab
☐ Debridement

NAIL UNIT HISTOPATHOLOGY

NAIL UNIT DYSTROPHY (Fungi/Neopiasm/Psoriasis)

☐ PCR, Periodic Acid-Schiff (PAS), and H & E stain
☐ Periodic Acid-Schiff (PAS) and H & E stain ony
☐ PCR only
☐ Pigmented Streak / Lesion (Rule out Melanoma/Tumor)

WOUND

☐ PCR, Wound, Fungal, Bacteria, and Resistence Genes
☐ Other: ____________

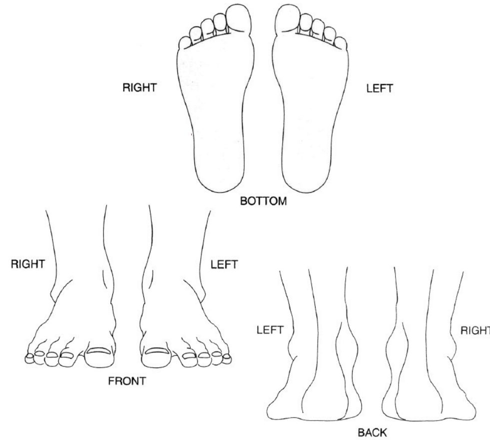
SKIN

☐ PIGMENTED LESION (Rule out Melanoma)
☐ NON-PIGMENTED LESION (Verruca/Rule out Melanoma)
☐ DERMATITIS (Eczematous/Tinea) - PAS Stain
☐ ULCERATION (Malignancy/Vasculitis)
☐ Other: ______________

SOFT TISSUE

☐ TUMOR (Ganglion/Lipoma/Sarcoma)
☐ INFLAMMATORY (Tophus/Abscess)
☐ Other: ________________

PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)



History of: ________________________________

SPECIMEN # 2 ☐ Left ☐ Right

☐ Biopsy
☐ Excision
☐ Aspiration/Crystal Analysis (fresh or in ETOH)
☐ PCR Swab
☐ Debridement

NAIL UNIT HISTOPATHOLOGY

NAIL UNIT DYSTROPHY (Fungi/Neopiasm/Psoriasis)

☐ PCR, Periodic Acid-Schiff (PAS), and H & E stain
☐ Periodic Acid-Schiff (PAS) and H & E stain ony
☐ PCR only
☐ Pigmented Streak / Lesion (Rule out Melanoma/Tumor)

WOUND

☐ PCR, Wound, Fungal, Bacteria, and Resistence Genes
☐ Other: ____________

SKIN

☐ PIGMENTED LESION (Rule out Melanoma)
☐ NON-PIGMENTED LESION (Verruca/Rule out Melanoma)
☐ DERMATITIS (Eczematous/Tinea) - PAS Stain
☐ ULCERATION (Malignancy/Vasculitis)
☐ Other: ______________

SOFT TISSUE

☐ TUMOR (Ganglion/Lipoma/Sarcoma)
☐ INFLAMMATORY (Tophus/Abscess)
☐ Other: ________________

7. Authorizations

I acknowledge that the laboratory has my permission to release my results directly to the treating physician or facility. I hearby authorize my insureance 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 deductables.

Patient 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).