bako
Integrated Physician Solutions

Bako Pathology Services
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LabForms 888-200-5114

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

PP670001

DATE COLLECTED ____/____/____ TIME COLLECTED _____

BILL: ☐ INSURANCE ☐ PATIENT

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	APT. #

CITY	STATE	ZIP CODE

PHONE NUMBER

DATE OF BIRTH / /	AGE	SEX	PATIENT ID

☐ Biomechanical Correlation (Plantar Skin)

BILLING/INSURANCE INFORMATION (ATTACH A COPY OF INSURANCE CARD - BOTH SIDES)

SUBSCRIBER PRIMARY INSURANCE	SUBSCRIBER SECONDARY INSURANCE
SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent	SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent
INSURANCE NAME	INSURANCE NAME
ADDRESS	ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
EMPLOYER NAME / MEMBER ID #	EMPLOYER NAME / MEMBER ID #
SUBSCRIBER DOB: / / / GROUP/CONTRACT #	SUBSCRIBER DOB: / / / GROUP/CONTRACT #
SUBSCRIBER SEX: ☐ Male ☐ Female / MEDICARE ID # / MEDICAID ID #	SUBSCRIBER SEX: ☐ Male ☐ Female / MEDICARE ID # / MEDICAID ID #

ADDITIONAL CLINICAL INFORMATION/DIAGNOSIS CODES (IF A CLINICAL IMAGE IS AVAILABLE PLEASE PRINT AND ATTACH)

CLINICAL INFORMATION

SPECIMEN #1 ☐ Right ☐ Left
☐ Biopsy ☐ Excision ☐ Aspiration (tumor)
☐ Aspiration/Crystal Analysis (fresh or in ETOH)

SKIN
☐ PIGMENTED LESION (Rule out Melanoma)
☐ NON-PIGMENTED LESION (Verruca/Rule out Carcinoma)
☐ DERMATITIS (Eczematous/Tinea)
☐ ULCERATION (Malignancy/Vasculitis)
☐ Other:_____

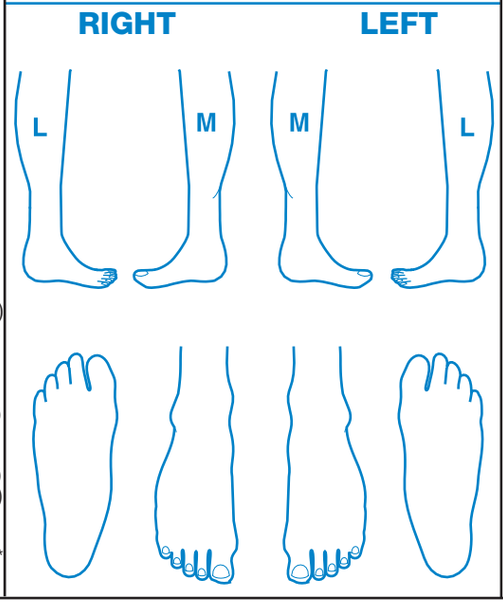
SOFT TISSUE
☐ TUMOR (Ganglion/Lipoma/Sarcoma)
☐ INFLAMMATORY (Tophus/Abscess)

BONE
☐ ARTHRITIS (HAV/Hammer Toe/DJD/Exostosis)
☐ LYTIC/DESTRUCTIVE (Ostemyelitis/Neoplasm)
☐ Other:_____

NAIL UNIT (Histopathology: choose stain(s) option)
NAIL UNIT DYSTROPHY (Fungi/Neoplasm/Psoriasis)
☐ Higher Sensitivity and melanin screen (PAS/GMS/FM) (Dematiaceous fungi / Melanoma)
☐ Higher Sensitivity (PAS/GMS)
☐ Routine (PAS)
FUNGAL SPECIATION (Typically added to above stain(s))
☐ PCR (3 Days) **OR** ☐ Culture (2-4 weeks)
RULE OUT NEOPLASIA
☐ PIGMENTED STREAK/LESION (R/O Melanoma)
☐ NON-PIGMENTED LESION (Verruca/ R/O Carcinoma)

BACTERIOLOGY (Open Wound)
☐ AEROBIC CX/SENSITIVITY/GRAM**
☐ AEROBIC/ANAEROBIC CX/SENSITIVITY/GRAM**
**Both may be performed with ESwab

PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)



SPECIMEN #2 ☐ Right ☐ Left
☐ Biopsy ☐ Excision ☐ Aspiration (tumor)
☐ Aspiration/Crystal Analysis (fresh or in ETOH)

SKIN
☐ PIGMENTED LESION (Rule out Melanoma)
☐ NON-PIGMENTED LESION (Verruca/Rule out Carcinoma)
☐ DERMATITIS (Eczematous/Tinea)
☐ ULCERATION (Malignancy/Vasculitis)
☐ Other:_____

SOFT TISSUE
☐ TUMOR (Ganglion/Lipoma/Sarcoma)
☐ INFLAMMATORY (Tophus/Abscess)

BONE
☐ ARTHRITIS (HAV/Hammer Toe/DJD/Exostosis)
☐ LYTIC/DESTRUCTIVE (Ostemyelitis/Neoplasm)
☐ Other:_____

NAIL UNIT (Histopathology: choose stain(s) option)
NAIL UNIT DYSTROPHY (Fungi/Neoplasm/Psoriasis)
☐ Higher Sensitivity and melanin screen (PAS/GMS/FM) (Dematiaceous fungi / Melanoma)
☐ Higher Sensitivity (PAS/GMS)
☐ Routine (PAS)
FUNGAL SPECIATION (Typically added to above stain(s))
☐ PCR (3 Days) **OR** ☐ Culture (2-4 weeks)
RULE OUT NEOPLASIA
☐ PIGMENTED STREAK/LESION (R/O Melanoma)
☐ NON-PIGMENTED LESION (Verruca/ R/O Carcinoma)

BACTERIOLOGY (Open Wound)
☐ AEROBIC CX/SENSITIVITY/GRAM**
☐ AEROBIC/ANAEROBIC CX/SENSITIVITY/GRAM**
**Both may be performed with ESwab

AFFIXED LABEL

PHYSICIAN SIGNATURE

The requested test(s) is/are medically indicated for patient management.

SIGNATURE REQUIRED

PATIENT SIGNATURE

I authorize Bako Pathology Services, LLC to bill my insurance.

SIGNATURE _____ DATE: ____/____/____

SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL

REQ. VERSION 09/22/2017