Bako Diagnostics
6240 SHILOH ROAD
ALPHARETTA, GA 30005
PH: 877-376-7284 • FAX: 770-475-0533

DATE COLLECTED ____/____/______ TIME COLLECTED ____________

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP CODE
PHONE NUMBER		
DATE OF BIRTH / /	AGE	SEX	PATIENT ID

BILL: ☐ **INSURANCE** ☐ **PATIENT** ☐ Biomechanical Correlation (Plantar Skin)

BILLING/INSURANCE INFORMATION (Attach a copy of primary / secondary insurance cards—both sides)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent	INSURANCE NAME		
MEMBER ID	ADDRESS		
GROUP/CONTRACT #	CITY	STATE	ZIP

DRY KERATIN REQUISITION

CLINICAL IMAGE?

☐ PRINTED AND ATTACHED

☐ SUBMITTED TO HTTPS://IMAGES.BAKODX.COM

CLINICAL INFORMATION

SPECIMEN #1 ☐ Right ☐ Left

☐ **COMPREHENSIVE NAIL ANALYSIS**
(PAS/GMS/FM/PCR)

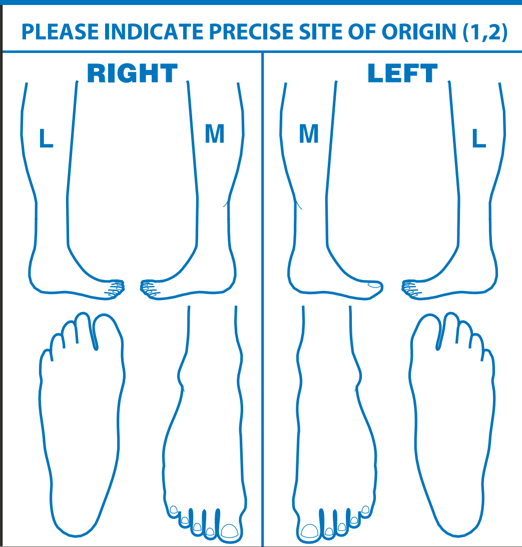
NAIL UNIT DYSTROPY (Fungal, Inflammatory, Neoplasm)
- ☐ Higher Sensitivity & Melanin Screen (PAS/GSM/FM) (Dematiaceous fungi / Melanoma)
- ☐ Higher Sensitivity (PAS/GMS)
- ☐ Routine (PAS)

FUNGAL SPECIATION / ORGANISM IDENTIFICATION
(Typically added to above stain(s))
☐ PCR (2 days) or ☐ Culture (2-4 weeks)

SKIN
- ☐ Dermatitis with PAS (Eczematous/Tinea)
- ☐ Other:____________________

ADDITIONAL INFORMATION / DIAGNOSIS CODES

PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)



SPECIMEN #2 ☐ Right ☐ Left

☐ **COMPREHENSIVE NAIL ANALYSIS**
(PAS/GMS/FM/PCR)

NAIL UNIT DYSTROPY (Fungal, Inflammatory, Neoplasm)
- ☐ Higher Sensitivity & Melanin Screen (PAS/GSM/FM) (Dematiaceous fungi / Melanoma)
- ☐ Higher Sensitivity (PAS/GMS)
- ☐ Routine (PAS)

FUNGAL SPECIATION / ORGANISM IDENTIFICATION
(Typically added to above stain(s))
☐ PCR (2 days) or ☐ Culture (2-4 weeks)

SKIN
- ☐ Dermatitis with PAS (Eczematous/Tinea)
- ☐ Other:____________________

ADDITIONAL INFORMATION / DIAGNOSIS CODES

Specimen 1	Specimen 2	Specimen 3
Name:	Name:	Name:

PHYSICIAN SIGNATURE

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

SIGNATURE REQUIRED

PATIENT SIGNATURE

I authorize Bako Diagnostics to bill my insurance.

SIGNATURE ____________________ DATE: ____/____/____

SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL