



**Bako Diagnostics**  
 6240 SHILOH ROAD  
 ALPHARETTA, GA 30005  
 PH: 877-376-7284 • FAX: 770-475-0528

**PHYSICIAN/CLINIC INFORMATION**

LAB  
USE  
ONLY

SPCR1500000

DATE COLLECTED \_\_\_\_ / \_\_\_\_ / \_\_\_\_ TIME COLLECTED \_\_\_\_ : \_\_\_\_

**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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		INSURANCE NAME		
MEMBER ID		ADDRESS		
GROUP/CONTRACT #	CITY	STATE	ZIP	

**ADDITIONAL CLINICAL INFORMATION: (If clinical image is available, please print and attach or submit digitally at [HTTPS://IMAGES.BAKODX.COM](https://images.bakodx.com))**

SPECIMEN #1	SPECIMEN #2
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Biopsy <input type="checkbox"/> Excision	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Biopsy <input type="checkbox"/> Excision

NAIL		
<p><b>NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)</b></p> <input type="checkbox"/> Higher Sensitivity and melanin screen (PAS/GMS/FM) (Dematiaceous fungi / Melanoma) <input type="checkbox"/> Higher Sensitivity (PAS/GMS) <input type="checkbox"/> Routine (PAS) <p><b>INFECTIOUS ONYCHODYSTROPHY: ORGANISM IDENTIFICATION</b>          (Typically added to above stain(s), DRY)  <input type="checkbox"/> PCR (2 Days) OR <input type="checkbox"/> Culture (2 – 4 weeks)</p> <p><b>NEOPLASIA</b></p> <input type="checkbox"/> Pigmented Streak/Lesion (R/O Melanoma) <input type="checkbox"/> Non-Pigmented Lesion (Verruca / R/O Carcinoma)	<p><b>PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)</b></p> <p style="font-size: 1.5em; font-weight: bold; color: #0070C0;">RIGHT      LEFT</p>	<p><b>NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)</b></p> <input type="checkbox"/> Higher Sensitivity and melanin screen (PAS/GMS/FM) (Dematiaceous fungi / Melanoma) <input type="checkbox"/> Higher Sensitivity (PAS/GMS) <input type="checkbox"/> Routine (PAS) <p><b>INFECTIOUS ONYCHODYSTROPHY: ORGANISM IDENTIFICATION</b>          (Typically added to above stain(s), DRY)  <input type="checkbox"/> PCR (2 Days) OR <input type="checkbox"/> Culture (2 – 4 weeks)</p> <p><b>NEOPLASIA</b></p> <input type="checkbox"/> Pigmented Streak/Lesion (R/O Melanoma) <input type="checkbox"/> Non-Pigmented Lesion (Verruca / R/O Carcinoma)

SKIN/SOFT TISSUE/BONE		
<p><b>SKIN</b></p> <input type="checkbox"/> Pigmented Lesion (Rule out Melanoma) <input type="checkbox"/> Non-Pigmented Lesion (Verruca/Rule out Carcinoma) <input type="checkbox"/> Dermatitis (Eczematous/Tinea) <input type="checkbox"/> Ulceration (Malignancy/Vasculitis) <input type="checkbox"/> Other: _____ <p><b>SOFT TISSUE</b></p> <input type="checkbox"/> Tumor (Ganglion/Lipoma/Sarcoma) <input type="checkbox"/> Inflammatory (Tophus/Abscess) <p><b>BONE</b></p> <input type="checkbox"/> Arthritis (HAV/Hammer Toe/DJD/Exostosis) <input type="checkbox"/> Lytic/Destructive (Osteomyelitis/Neoplasm) <input type="checkbox"/> Micro (Aerobic /Anaerobic) No Formalin <input type="checkbox"/> Other: _____	<p style="font-size: 1.5em; font-weight: bold; color: #0070C0;">RIGHT      LEFT</p>	<p><b>SKIN</b></p> <input type="checkbox"/> Pigmented Lesion (Rule out Melanoma) <input type="checkbox"/> Non-Pigmented Lesion (Verruca/Rule out Carcinoma) <input type="checkbox"/> Dermatitis (Eczematous/Tinea) <input type="checkbox"/> Ulceration (Malignancy/Vasculitis) <input type="checkbox"/> Other: _____ <p><b>SOFT TISSUE</b></p> <input type="checkbox"/> Tumor (Ganglion/Lipoma/Sarcoma) <input type="checkbox"/> Inflammatory (Tophus/Abscess) <p><b>BONE</b></p> <input type="checkbox"/> Arthritis (HAV/Hammer Toe/DJD/Exostosis) <input type="checkbox"/> Lytic/Destructive (Osteomyelitis/Neoplasm) <input type="checkbox"/> Micro (Aerobic /Anaerobic) No Formalin <input type="checkbox"/> Other: _____

<p>Specimen 1 SPCR1500000 Name: _____</p>	<p>Specimen 2 SPCR1500000 Name: _____</p>	<p>Specimen 3 SPCR1500000 Name: _____</p>
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PHYSICIAN SIGNATURE	
<p>The requested test(s) is/are medically indicated for patient management.</p> <p style="text-align: center; font-weight: bold; color: red; font-size: 1.2em;">SIGNATURE REQUIRED</p>	<p>I authorize Bako Diagnostics to bill my insurance.</p> <p>SIGNATURE _____ DATE ____ / ____ / ____</p>

**SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL**

Version 01.09.20

**SKIN MOLECULAR/ DNA**

**Web Space Panel tests for:**

- Pan-Dermatophytes
- Candida* spp
- Corynebacterium minutissimum*
- Pan gram-negative bacteria
- Staphylococcus aureus*\*

\*With reflex to *mecA*

