bako dx

855-422-5628 Fax: 770-475-0528

Bako Diagnostics
6240 Shiloh Rd
Alpharetta, GA 30005

Date collected: _____ /_____ /_____

Time collected: _____

Version 4/17/22

PHYSICIAN / CLINIC INFORMATION

LAB USE ONLY

DERMATOLOGY REQUISITION

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Apt/Suite:_____ City:_____ State:__ __ Zip Code:_____

Date of Birth:__ __ / __ __ / __ __ __ __ Sex:_____ Patient ID:_____ Phone #:__ __ __ - __ __ __ - __ __ __ __

BILLING INFORMATION *(Attach a copy of primary/secondary insurance cards– both sides)*

Bill:
☐ Insurance
☐ Patient

Primary Medical Insurance
Insured Name: _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Insurance Provider: _____
Member ID: _____
Group#: _____

CLINICAL INFORMATION

Specimen		Skin	Nail
A Site:_____ **Additional Clinical Notes:** **ICD 10** (Required for PCR testing) ☐ Clinical image submitted to: https://images.bakodx.com	**A** ☐ Margins: _____ ☐ Excision ☐ Shave ☐ Punch ☐ Other	☐ Pigmented Lesion (Rule out Melanoma) ☐ Non-Pigmented Lesion (Verruca/Rule out Carcinoma) ☐ Dermatitis (Eczematous/Tinea) ☐ Ulceration (Malignancy/Vasculitis) ☐ Other: _____	**NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)** ☐ Higher Sensitivity & Melanin Screen (PAS / GMS / FM) (Dematiaceous fungi / Melanoma) ☐ Higher Sensitivity (PAS / GMS) ☐ Routine (PAS) **FUNGAL SPECIATION / ORGANISM IDENTIFICATION** (Typically added to above stain(s)) **Fungal PCR w/ terbinafine resistance reflex*** ☐ w/ Pseudomonas ☐ w/o Pseudomonas **Fungal PCR w/o terbinafine resistance reflex** ☐ w/ Pseudomonas ☐ w/o Pseudomonas ☐ Pseudomonas ONLY ☐ Fungal Culture **NEOPLASIA** ☐ Pigmented Streak / Lesion (R/O Melanoma) ☐ Non-Pigmented / Lesion (Verruca / R/O Carcinoma) **Terbinafine resistance not available in NY*
B Site:_____ **Additional Clinical Notes:** **ICD 10** (Required for PCR testing) ☐ Clinical image submitted to: https://images.bakodx.com	**B** ☐ Margins: _____ ☐ Excision ☐ Shave ☐ Punch ☐ Other	☐ Pigmented Lesion (Rule out Melanoma) ☐ Non-Pigmented Lesion (Verruca/Rule out Carcinoma) ☐ Dermatitis (Eczematous/Tinea) ☐ Ulceration (Malignancy/Vasculitis) ☐ Other: _____	**NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)** ☐ Higher Sensitivity & Melanin Screen (PAS / GMS / FM) (Dematiaceous fungi / Melanoma) ☐ Higher Sensitivity (PAS / GMS) ☐ Routine (PAS) **FUNGAL SPECIATION / ORGANISM IDENTIFICATION** (Typically added to above stain(s)) **Fungal PCR w/ terbinafine resistance reflex*** ☐ w/ Pseudomonas ☐ w/o Pseudomonas **Fungal PCR w/o terbinafine resistance reflex** ☐ w/ Pseudomonas ☐ w/o Pseudomonas ☐ Pseudomonas ONLY ☐ Fungal Culture **NEOPLASIA** ☐ Pigmented Streak / Lesion (R/O Melanoma) ☐ Non-Pigmented / Lesion (Verruca / R/O Carcinoma) **Terbinafine resistance not available in NY*
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PHYSICIAN SIGNATURE

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

SIGNATURE REQUIRED_____

PATIENT SIGNATURE

I authorize BakoDx to bill my insurance and understand I am responsible for paying any uncovered amount.

SIGNATURE REQUIRED_____ DATE___/___/___

A	B	C	
Name:_____	Name:_____	Name:_____	
Site:_____	Site:_____	Site:_____	

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A	B	C	
Name:_____	Name:_____	Name:_____	
Site:_____	Site:_____	Site:_____	