PDK10001

Bako Pathology Services
6240 SHILOH ROAD
ALPHARETTA, GA 30005
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PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

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

CLINICAL IMAGE?
☐ PRINTED AND ATTACHED
☐ SUBMITTED TO HTTPS://IMAGES.BAKOCTS.COM/

DRY KERATIN REQUISITION

PRIMARY INSURANCE (ATTACH A COPY OF INSURANCE CARD – BOTH SIDES)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent

INSURANCE NAME		
ADDRESS		
CITY	STATE	ZIP CODE
EMPLOYER NAME	MEMBER ID #	
SUBSCRIBER DOB: / /	GROUP/CONTRACT #	
SUBSCRIBER SEX: ☐ Male ☐ Female	MEDICARE ID #	MEDICAID ID #

SECONDARY INSURANCE (ATTACH A COPY OF INSURANCE CARD – BOTH SIDES)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent

INSURANCE NAME		
ADDRESS		
CITY	STATE	ZIP CODE
EMPLOYER NAME	MEMBER ID #	
SUBSCRIBER DOB: / /	GROUP/CONTRACT #	
SUBSCRIBER SEX: ☐ Male ☐ Female	MEDICARE ID #	MEDICAID ID #

CLINICAL INFORMATION

SPECIMEN #1 ☐ Right ☐ Left

NAIL UNIT (Histopathology: choose stain(s) option)

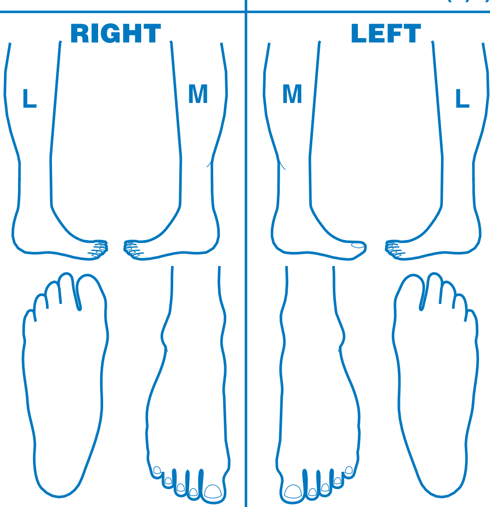
NAIL UNIT DYSTROPHY (Fungi / Neoplasm / Psoriasis)
- ☐ Higher Sensitivity and melanin screen (PAS/GMS/FM) (Dematiaceous fungi / Melanoma)
- ☐ Higher Sensitivity (PAS/GMS)
- ☐ Routine (PAS)

FUNGAL SPECIATION (Typically added to above stain(s))
☐ PCR (3 Days) **OR** ☐ Culture (2-4 weeks)

SKIN
- ☐ DERMATITIS w/PAS (Eczematous/Tinea)
- ☐ Other:________________

ADDITIONAL INFORMATION / DIAGNOSIS CODES

PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)



SPECIMEN #2 ☐ Right ☐ Left

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)

SKIN
- ☐ DERMATITIS w/PAS (Eczematous/Tinea)
- ☐ Other:________________

ADDITIONAL INFORMATION / DIAGNOSIS CODES

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