Practice Information

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Elmwood Park NJ 07407
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Lab Director: Robert L Rush
CLIA #31D2063148

WOUND - RPP - UTI - GPP REQUISITION FORM

1. PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Sex: ☐ F ☐ M DOB __/__/____ Resides: ☐ Home ☐ Facility

Name of Facility: ☐ N/A _____

Address: _____

City, State, ZIP: _____

Facility Contact Person: _____

Facility Contact Phone: _____

2. PROVIDER INFORMATION

TYPE: ☐ Clinic ☐ Facility ☐ Home Health ☐ Home visit Provider ☐ Other

.....Ordering Provider Information ONLY.....

Type Name: _____

Address: _____ City, State, ZIP: _____

Provider Phone: _____

Provider Name(s) & NPI: _____

3. SPECIMEN COLLECTION

Date of Collection: _____ Time: _____ ☐ AM ☐ PM

Collected by: _____

TYPE: ☐ NASAL ☐ URINE ☐ THROAT ☐ Clean Catch

☐ SKIN WOUND/SOFT TISSUE ☐ Catheter

Location Swabbed _____

4. DIAGNOSTIC INFORMATION

PRIMARY DIAGNOSES _____

ICD-10 _____

SECONDARY DIAGNOSES _____

ICD-10 _____

5. PAYMENT INFORMATION

BILL: ☐ Patient ☐ Insurance ☐ Other

☐ See attached copy of patient demographics/insurance info

Primary Insured Name:

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company: _____

Member ID# _____ Group ID# _____

City, State, ZIP: _____

6. SCREENINGS AND PANELS

☐ 01. WOUND PANEL
☐ 02. RPP
☐ 03. UTI

☐ **Include ABR** (ANTIBIOTIC RESISTENT PANEL)

-Wound Panel
-RPP
-UTI

RESULTS: RESULTS SENT TO: (SELECT ALL THAT APPLY)

☐ Physicians Portal

☐ Email ☐ Fax

BACKUP RESULTS SENT:

☐ Email ☐ Fax

7. PATIENT AUTHORISATION

I authorize Suretox to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Suretox for services I received. I understand that Suretox may be an out-of-network provider with my insurer. I also understand that in sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Suretox immediately. Failure to send payment with 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature: _____ Date: _____

8. PHYSICIAN SIGNATURE

I authorize the above ordered test(s)

Authorized healthcare Provider Signature: _____ Date: _____