

Patient Details		Demographics Attached		Provider Information:	
Last Name: _____		M.I. _____			
First Name _____		Date of Birth: _____			
Address: _____					
City, State, Zip _____					
Phone #: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Patient Insurance Details					
Primary Insurance Carrier: _____			Insured name: _____		Date of Birth: _____
Policy #: _____			Group #: _____		
Authorization Code: _____			<input type="checkbox"/> SELF PAY / NO INSURANCE         Relation to insured: (Select one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian		

Relevant Clinical Information & ICD10					
REQUIRED -		Date of Collection: _____	Time of Collection: _____	Collector Initials: _____	
ICD10 (REQUIRED)					
<input type="checkbox"/> Z16.29 Resistance to other single spec. anti <input type="checkbox"/> L85.8 Other specified epidermal thickening <input type="checkbox"/> B96.89 Other specified bacterial agent <input type="checkbox"/> B95.2 Enterococcus <input type="checkbox"/> 95.7 Other Staphylococcus <input type="checkbox"/> N76.0 Vaginitis <input type="checkbox"/> N77.1 Vaginitis, vulvitis and vulvovaginitis in diseases classified elsewhere.		<input type="checkbox"/> Z16.29 Resistance to other single spec. anti <input type="checkbox"/> L85.8 Other specified epidermal thickening <input type="checkbox"/> B96.89 Other specified bacterial agent <input type="checkbox"/> B96.5 Pseudomonas <input type="checkbox"/> L89. _____ Pressure Ulcer (6-digit code Req'd) <input type="checkbox"/> L97. _____ Non-Pressure Ulcer (6-digit code Req'd)		<input type="checkbox"/> L60.0 Ingrown toenails <input type="checkbox"/> 7835.1 Onychomycosis <input type="checkbox"/> B35.3 Tinea Pedis <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
<input type="checkbox"/> B49 Unspecified Mycosis <input type="checkbox"/> L03.011 Cellulitis of the right finger <input type="checkbox"/> L03.012 Cellulitis of the left finger <input type="checkbox"/> L03.021 Cellulitis of the right toe <input type="checkbox"/> L03.022 Cellulitis of the left toe <input type="checkbox"/> L03.03 Cellulitis of toe <input type="checkbox"/> I87.311 Chronic venous hypertension w/ ulcer of right low extremity		<input type="checkbox"/> L60.8 Other nail disorders <input type="checkbox"/> L60.1 Onycholysis <input type="checkbox"/> L60.4 Beau's Lines <input type="checkbox"/> L60.3 Nail Dystrophy <input type="checkbox"/> L03.019 Cellulitis of unspecified finger <input type="checkbox"/> L03.115 Cellulitis of right lower limb <input type="checkbox"/> L60.5 Yellow nail syndrome <input type="checkbox"/> L03.81 Cellulitis of other sites		<input type="checkbox"/> L08.89 Other Specified Local Infections of the Skin & Subcutaneous Tissue <input type="checkbox"/> L02.91 Cutaneous Abscess, Unspecified <input type="checkbox"/> L03.116 Cellulitis of left lower limb <input type="checkbox"/> I87.313 Chronic venous hypertension w ulcer of bilateral low extremity <input type="checkbox"/> I87.312 Chronic venous hypertension w ulcer of left low extremity <input type="checkbox"/> E11.621 Type 2 diabetes mellitus with foot ulcer <input type="checkbox"/> E11.622 Type 2 diabetes mellitus with other skin ulcer <input type="checkbox"/> R21 Rash and other nonspecific skin eruption	
<input type="checkbox"/> R30.0 Dysuria <input type="checkbox"/> R30.9 Painful Micturition, unspecified <input type="checkbox"/> R10.2 Pelvic & Perineal pain <input type="checkbox"/> N97.0 Female Infertility <input type="checkbox"/> B44.9 Aspergillus Unspecified <input type="checkbox"/> N89.8 Other specified noninflammatory disorders of vaginitis <input type="checkbox"/> N76.89 Other specified inflammation of vagina and vulva <input type="checkbox"/> Other _____					

Test Menu					
Urine Sample		SPECIMEN A		SPECIMEN B	
Collect in Vacutainer		Collect in Eswab		Collect in Eswab	
<input type="checkbox"/> Urinary Tract Infection		Location of Infection: _____		Location of Infection: _____	
<input type="checkbox"/> Panel includes		<input type="checkbox"/> Panel includes		<input type="checkbox"/> Panel includes	
<b>Bacteria</b> Escherichia coli Streptococcus agalactiae Klebsiella oxytoca Staphylococcus saprophyticus Serratia marcescens Porteus mirabilis Aerococcus urinae Treponema pallidum Enterobacter cloacae Pseudomonas aeruginosa Citrobacter freundii Klebsiella aerogenes Klebsiella pneumoniae Morganella morganii Enterococcus faecium Enterococcus faecalis Acinetobacter baumannii Proteus vulgaris Staphylococcus aureus Ureplasma Providencia stuartii Cornebacterium urealyticum		<b>BACTERIA</b> Escherichia coli Streptococcus agalactiae Klebsiella oxytoca Staphylococcus saprophyticus Pseudomonas aeruginosa Staphylococcus haemolyticus Enterococcus faecium Enterococcus faecalis Acinetobacter calcoaceticus-baumannii complex Candida krusei Candida albicans Candida parapsilosis Candida tropicalis Fusarium solani Trichophyton spp Candida glabrata Microsporium spp		<b>BACTERIA</b> Escherichia coli Streptococcus agalactiae Klebsiella oxytoca Staphylococcus saprophyticus Pseudomonas aeruginosa Staphylococcus haemolyticus Enterococcus faecium Enterococcus faecalis Acinetobacter calcoaceticus-baumannii complex Candida krusei Candida albicans Candida parapsilosis Candida tropicalis Fusarium solani Trichophyton spp Candida glabrata Microsporium spp	
<b>Fungi</b> Candida parapsilosis Candida glabrata Candida auris Candida tropicalis Candida krusei Candida albicans		<b>FUNGI</b> Candida albicans Candida parapsilosis Candida tropicalis Fusarium solani Trichophyton spp Candida glabrata Microsporium spp		<b>FUNGI</b> Candida albicans Candida parapsilosis Candida tropicalis Fusarium solani Trichophyton spp Candida glabrata Microsporium spp	
<b>ANTIMICROBIAL RESISTANCE</b> Methicillin Resistance (MecA+C) <input type="checkbox"/> Fungal & Nail PCR		<b>ANTIMICROBIAL RESISTANCE</b> Methicillin Resistance (MecA+C) <input type="checkbox"/> Fungal & Nail PCR		<b>ANTIMICROBIAL RESISTANCE</b> Methicillin Resistance (MecA+C) <input type="checkbox"/> Fungal & Nail PCR	
<b>ANTIBIOTIC RESISTANCE GENE</b> CTX-M ESBL KPC - Carbapenem resistance NDM - Carbapenem resistance VIM - Carbapenem resistance IMP - Carbapenem resistance qnr - Quinolone resistance vanB - Vancomycin resistance OXA-48 - Carbapenem resistance mecA/mecC - Methicillin resistance Sul - Sulfonamide resistance vanA - Vancomycin resistance dfrA - Trimethoprim resistance		<b>ANTIBIOTIC RESISTANCE GENE</b> Malassezia symyodialis Mentagrophytes/interdigitale Microsporium audouinii Microsporium canis Microsporium gypseum Trichophyton Trichophyton rubrum Trichophyton soudanense Trichophyton terrestris Trichophyton tonsurans Trichophyton verrucosum Trichophyton violaceum Trichosporon asahii Trichosporon mucoides		<b>ANTIBIOTIC RESISTANCE GENE</b> Malassezia symyodialis Mentagrophytes/interdigitale Microsporium audouinii Microsporium canis Microsporium gypseum Trichophyton Trichophyton rubrum Trichophyton soudanense Trichophyton terrestris Trichophyton tonsurans Trichophyton verrucosum Trichophyton violaceum Trichosporon asahii Trichosporon mucoides	

**Physician Authorization**  
I, the undersigned healthcare provider, acknowledge that when ordering a Urinary Tract Infection (UTI), Nail, or Wound PCR panel through North West Labs, located at 29580 Northwestern Hwy., Suite 120, Southfield, MI 48034 (NPI: 1568994879, Tax ID: 813538903) I understand and agree to the following terms:

- In some or all instances, UTI, Wound, and Nail panels and their associated antibiotic resistance markers tests will be forwarded to PCR Labs of America (1464 E Whitestone Blvd, Ste 2401, Cedar Park, TX 78613; Phone: (512) 456-0071; Fax: (512) 456-0072) for processing and analysis.
- Any pathology, cytology, and thin prep specimens will be forwarded to KC Pathology Laboratory (44400 Van Dyke Ave, Ste 102, Sterling Heights, MI 48314; Phone: (586) 262-4243; Podiatric Pathology Form Fax: (586) 262-4241) for evaluation and reporting.
- I understand that while the initial order is placed with North West Labs, the actual testing may be performed by their partner laboratories as specified above.
- I acknowledge that this referral process may affect billing procedures and timeline for results, and I accept this as part of the standard operating procedure for these specific test types.
- I confirm that I have informed my patients about this testing arrangement as appropriate and in accordance with applicable regulations.

**Patient Consent and Authorization**  
I authorize the release of my medical information including test results for submission of personalized reports to my healthcare providers and insurance carrier(s). I request that payment of benefits be made to North West Labs, Inc. on my behalf. If my policy does not allow for direct payment, I agree to relinquish allocated funds to North West Labs, Inc as compensation for services rendered. I also acknowledge that I will be liable for payments of deductibles, co payments and/or co insurance as detailed by my healthcare insurer. I understand that I am liable for charges not covered by my healthcare insurer. I also authorize North West Labs, Inc to appeal insurance claims on my behalf. I acknowledge the benefits, risk and limitations of this testing as describe to me by a qualified healthcare provider. My insurance may not cover or pay full amount for testing; I may be responsible for full or part of amount charged due to out of network benefits, deductible and co pays. North West Labs, Inc has my permission to bill my insurance carrier(s), this notice gives me the option to proceed with the procedure or decline. By signing this I have read all of the above and understand it. Medicare Advance Beneficiary Notice: Medicare will only pay for services that it determines to be reasonable and necessary under section 1882 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare Program standards, Medicare will deny payment for that service. Medicare usually does not pay for these tests for the reported diagnosis. By signing the Patient/Responsible Party Signature on this requisition, you are confirming your agreement to assume financial responsibility for the payment of these tests.

Physician Signature _____	Date: _____
Patient Signature _____	Date: _____