

Practice Information



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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 RESISTANT 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: _____