



WOUNDREQUISITION FORM

Practice Information

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. 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: _____

☐ No Fault, Workers Comp Claim # _____

Adjuster Name: _____ Phone# _____

Date of Injury ____/____/____ Body Part: _____

3. SPECIMEN COLLECTION

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

Collected by: _____

TYPE: Wound (Swab)/Location Swabbed _____

4. DIAGNOSTIC INFORMATION

ICD-10 CODES:

- | | |
|--|--|
| ☐ A48.8: Other specified bacterial disease | ☐ R53.81: Other malaise |
| ☐ R59.0: Enlarged lymph nodes, unspecified | ☐ Z22.330: Carrier of Group B Streptococcus |
| ☐ M25.50: Joint pain unspecified | ☐ A49.9: Bacterial Infection unspecified |
| ☐ R53.1: Weakness | ☐ B99.9: Unspecified infectious disease |
| ☐ M79.1: Myalgia | ☐ R51: Headache |
| ☐ 40.1: Stupor | ☐ R57.9: Shock |
| ☐ R50.9: Fever | ☐ R59.0: Enlarged lymph nodes, unspecified |
| ☐ R63.0: Anorexia | ☐ Z20.89: Suspected exposure to other communicable disease |

5. PATHOGENS TESTED

Aerobic Bacteria, Gram-Positive: Enterococcus faecalis, Enterococcus faecium, Mycobacteroides abscessus, Mycobacterium chelonae, Staphylococcus aureus, Klebsiella oxytoca, Klebsiella pneumoniae, Staphylococcus epidermidis, Staphylococcus

Aerobic Bacteria, Gram-Negative: Acinetobacter baumannii, Citrobacter freundii, Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Proteus mirabilis, Proteus vulgaris, Pseudomonas aeruginosa.

Aerobic Bacteria, Gram-Negative: Acinetobacter baumannii, Citrobacter freundii, Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Proteus mirabilis, Proteus vulgaris, Pseudomonas aeruginosa.

Anaerobic Bacteria, Gram-Positive: Clostridium perfringens, Clostridium septicum.

Anaerobic Bacteria, Gram-Negative: Bacteroides fragilis, Prevotella intermedia, Prevotella oralis.

Fungi: Aspergillus flavus, Aspergillus fumigatus, Aspergillus niger, Candida albicans, Candida glabrata, Candida parapsilosis, Candida tropicalis, Candida

6. 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

Patient Signature: _____

7. PHYSICIAN SIGNATURE

I authorize the above ordered test(s)

Provider Signature: _____