GeneStreet Laboratories

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Hair / Nail / Wound Pathogen Test Requisition

1. PATIENT INFORMATION (REQUIRED)

Please attach a copy of patient demographic sheet

First Name_____ Last Name_____
DOB (mm/dd/yyyy) _____ ☐ Male ☐ Female Age_____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

3. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Telephone: _____

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE: Please attach a copy of front and back of insurance card**

☐ **SELF-PAY:** Gene Street Laboratories will contact patient to obtain payment

☐ **CLIENT BILL OR INSTITUTION BILL**

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ **Collected By**_____

Specimen Type

☐ Hair Clipping
☐ Nail Clipping/Wound Swab right
☐ Nail Clipping/Wound Swab left

5. TEST(S) REQUESTED

☐ **HAIR/NAIL INFECTIOUS DISEASE PATHOGENS (checking this box includes the 25 pathogens listed below)**

Bacterial/Viral				
Bacteroides fragilis, vulgatus	Escherichia coli	Peptostreptococcus anaerobius, asaccharolyticus, magnus, prevotii	Pseudomonas aeruginosa	Staphylococcus aureus
Enterobacter aerogenes, cloacae	Fusobacterium nucleatum, necrophorum		Serratia marcescens	Streptococcus agalactiae
Enterococcus faecalis, faecium	Klebsiella pneumoniae, oxytoca	Proteus mirabilis, vulgaris	Staphylococcus[12]	Streptococcus pyogenes
Fungal				
Aspergillus flavus, fumigatus, niger, terreus	Cladosporium herbarum	Epidermophyton floccosum	Microsporum audouinii, canis, gypseum	Trichophyton mentagraphophytes /interdigitale, rubrum, soudanense, terrestre, tonsurans, verrucosum, violaceum
Blastomyces dermatitidis	Fusarium oxysporum, solani	Malassezia furfur, restricta, sympodialis, globosa		
Candida albicans, glabrata, parapsilosis, tropicalis	Curvularia lunata		Trichosporon mucoides, asahii	

☐ **WOUND INFECTIOUS DISEASE PATHOGENS (checking this box includes the 40 pathogens listed below)**

Bacterial/Viral				
Acinetobacter baumani	Enterobacter aerogenes, cloacae	Mycoplasma genitalium, hominis	Serratia marcescens	Streptococcus pneumoniae
Anaerococcus vaginalis	Enterococcus faecalis, faecium	Peptoniphilus harei, ivorii	Staphylococcus (coagulase negative: epidermidis, haemolyticus, lugdunensis, saprophyticus)	Streptococcus pyogenes
Bacteroides fragilis, vulgatus	Escherichia coli	Peptostreptococcus anaerobius, asaccharolyticus, magnus, prevotii		Vibrio cholerae, parahaemolyticus, vulnificus
Burkholderia cepacia, pseudomallei	Finegoldia magna			
Clostridium perfringens, novyi, septicum	Fusobacterium nucleatum, necrophorum	Cutibacterium (Propionibacterium) acnes		Varicella zoster virus
Corynebacterium jeikeium, striatum, tuberculostearicum	Haemophilus influenzae	Proteus mirabilis, vulgaris	Staphylococcus aureus	
	Herpes simplex virus 1 & 2	Pseudomonas aeruginosa	Stenotrophomonas maltophilia	
Citrobacter freundii	Klebsiella pneumoniae, oxytoca	Salmonella enterica	Streptococcus agalactiae	
Fungal				
Aspergillus flavus, fumigatus, niger, terreus	Candida albicans, glabrata, parapsilosis, tropicalis	Curvularia lunata	Trichophyton mentagraphophytes/interdigitale, rubrum, soudanense, terrestre, tonsurans, verrucosum, violaceum	
		Fusarium oxysporum, solani		
Blastomyces dermatitidis	Cladosporium herbarum	Malassezia furfur, restricta,	Trichosporon mucoides, asahii	

☐ **Antibiotic Resistance Reflex Testing (ABR testing is only performed if a pathogen is detected in the Infectious Disease Panel ordered)**

VanA, VanB (Vancomycin genes)	PER-1/VEB-1/GES-1 Groups	dfr (A1, A5), sul (1, 2) probes	tet B, tet M (Tetracycline genes)	qnrA1, qnrA2, qnrB2	OXA-48,-51 (Class D oxacillinase)
ermB, C; mefA	SHV, KPC Groups	mecA (Methicillin gene)	IMP, NDM, VIM Groups	ACT, MIR, FOX, ACC Groups	CTX-M1 (15), M2 (2), M9 (9), M8/25 Groups

6. ICD10 CODES

☐ B35.1 Tinea unguium	☐ L02.611 Cutaneous abscess of right foot	☐ S91.32 Laceration with foreign body of foot
☐ L54 Erythema in diseases classified elsewhere	☐ L02.612 Cutaneous abscess of left foot	☐ S91.33 Puncture wound without foreign body of foot
☐ R60.0 Localized edema	☐ S91.301A Unspecified open wound, right foot, initial encounter	☐ S91.34 Puncture wound with foreign body of foot
☐ M79.674 Pain in right toe(s)	☐ S91.302B Unspecified open wound, left foot, initial encounter	☐ S91.1 Open wound of toe without damage to nail
☐ M79.675 Pain in left toe(s)	☐ S91.301D Unspecified open wound, right foot, subsequent encounter	☐ S91.2 Open wound of toe with damage to nail
☐ R26.2 Difficulty in walking, not elsewhere classified	☐ S91.302D Unspecified open wound, left foot, subsequent encounter	☐ E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy
☐ L03.031 Cellulitis of right toe	☐ S91.301S Unspecified open wound, right foot, sequela	
☐ L03.032 Cellulitis of left toe	☐ S91.302S Unspecified open wound, left foot, sequela	☐ E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
☐ S91.35 Open bite of foot	☐ S91.31 Laceration without foreign body of foot	

7. PATIENT INFORMED CONSENT

By signing below, I, the patient, confirm that I have been informed about the details of the test(s) ordered for me by my provider. I have read the informed consent and I give permission to GeneStreet to perform laboratory testing as described. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I authorize GeneStreet to act as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service and to inform my health plan of my test result only if required for preauthorization or payment of test(s) ordered or additional reflex testing. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I also authorize the release of my medical information necessary to process this claim. I understand that genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory. I understand and agree that my leftover specimen and clinical information may be used, without information directly identifying me, for research, education, and other business purposes of GeneStreet (each a "secondary use" and together "secondary uses"). I understand that this may involve GeneStreet sharing my leftover specimen and clinical information with other third parties. My leftover specimen and clinical information will be assigned a unique code before any secondary uses. My name or other personal identifying information will not be used in or linked to my specimen and clinical information when they are shared with third parties unless I explicitly authorize that disclosure. I understand that GeneStreet, itself or through its contractors on its behalf, may contact me at a later date regarding my interest in participating in other research activities, including contributing additional clinical information or specimens for use in such activities and/or authorizing the use of my deidentifiable information for secondary uses. I understand and agree that this authorization and consent is voluntary. This specimen was provided voluntarily for analysis and I authorize GeneStreet to process, bill and provide results. I authorize that payment(s) be made on my behalf to GeneStreet for any services provided to me by GeneStreet.

Patient Signature: _____ **Date:** _____

8. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

I attest that the patient has received and read the GeneStreet Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any GeneStreet Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY: By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Ordering Physician Signature _____ **Date** _____