



22875 Savi Ranch Pkwy , Unit B
Yorba Linda , CA 92887
CLIA ID : 05D2184501

PLACE BARCODE LABEL HERE

Clinic/Facility Name: _____
Account #: _____
Address: _____

Provider Name: _____
NPI #: _____

WOUND MOLECULAR TEST REQUISITION FORM

1 PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone #: _____ Email: _____ Gender: M F
Race: White/Caucasian Asian American Indian/Native Alaskan Black/African American Native Hawaiian/Pacific Islander Multi-Race Other
 Prefer not to Answer
Ethnicity: Hispanic or Latino Not Latino or Hispanic

2 INSURANCE INFORMATION

Billing Method: Insurance Cash Pay Institutional Bill
Insurance Name: _____ Member ID #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____ Relationship to Patient: _____

3 SPECIMEN INFORMATION

Specimen Type: Wound swab Collection Date: _____ Time: _____ AM PM
*Patient should have no food or beverage at least 30 minutes prior to specimen collection as this may result in interference which can produce inaccurate results.

4 WOUND PCR MOLECLAR TEST PANEL

Wound Molecular PCR Panel
 ABX Panel (Antibiotic Resistance Gene Panel)

5 ICD-10 DIAGNOSIS CODE(S)

Physician Signature: _____ Date: _____

