PREMIER GENOMICS
INFECTIOUS DISEASE

NAIL FUNGAL PANEL REQUISITION

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	Sex ☐ Male ☐ Female
Street Address	City, State, Zip	Contact #

Patient Ethnicity ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Black ☐ Hispanic
☐ American Indian/Native Alaskan ☐ Asian ☐ Other/Unknown

PATIENT HISTORY (please use separate page if necessary)	Allergies

Current Medications

Patient acknowledgement for direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to the lab rendering the test and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize this lab to be my Designated Representative for purposes of appealing any denial of benefits. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending the lab any money received from my health insurance company for performance of this test. Further, I authorize the provider to release any pertinent medical records.

Patient or Legally Authorized Representative Date Patient Email

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

NPI #	Name (Last, First)	Facility Name
Street Address	City, State, Zip	
Phone	Fax	Email

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order infectious disease testing OR is a representative of a licensed medical professional authorized to order infectious disease testing: acknowledges the patient has been supplied information regarding infectious disease testing and the patient has given consent for infectious disease testing to be performed. I request clinical interpretation of these results and confirm that this testing is medically necessary for the diagnosis or detection of a disease and that these will be used in the medical management and treatment decisions for this patient. Further, the recipient's information is true and correct to the best of my knowledge.

Medical Professional Signature Date

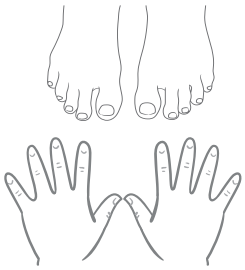
SPECIMEN INFORMATION

Date of Collection | Time of Collection

ICD-10 CODES ☐ L60.5 Yellow nail syndrome ☐ L60.9 Nail disorder, unspecified ☐ L60.8 Other nail disorders
☐ B35.1 Tinea unguium ☐ L03.039 Cellulitis of unspecified toe ☐ L03.019 Cellulitis of unspecified finger ☐ L60.1 Onycholysis
☐ B36.9 Superficial mycosis, unspecified ☐ L60.3 Nail dystrophy ☐ B35.9 Dermatophytosis, unspecified ☐ Other: _____

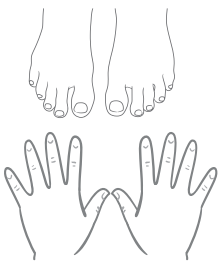
TEST SELECTION AND CLINICAL INFORMATION

Specimen #1 ☐ Fungal Speciation - PCR Specimen Source ☐ Toe Nail ☐ Finger Nail



Modifier	Description	Modifier	Description
TA	Left foot, great toe	FA	Left hand, thumb
T1	Left foot, second digit	F1	Left hand, second digit
T2	Left foot, third digit	F2	Left hand, third digit
T3	Left foot, fourth digit	F3	Left hand, fourth digit
T4	Left foot, fifth digit	F4	Left hand, fifth digit
T5	Right foot, great toe	F5	Right hand, thumb
T6	Right foot, second digit	F6	Right hand, second digit
T7	Right foot, third digit	F7	Right hand, third digit
T8	Right foot, fourth digit	F8	Right hand, fourth digit
T9	Right foot, fifth digit	F9	Right hand, fifth digit

Specimen #2 ☐ Fungal Speciation - PCR Specimen Source ☐ Toe Nail ☐ Finger Nail



Modifier	Description	Modifier	Description
TA	Left foot, great toe	FA	Left hand, thumb
T1	Left foot, second digit	F1	Left hand, second digit
T2	Left foot, third digit	F2	Left hand, third digit
T3	Left foot, fourth digit	F3	Left hand, fourth digit
T4	Left foot, fifth digit	F4	Left hand, fifth digit
T5	Right foot, great toe	F5	Right hand, thumb
T6	Right foot, second digit	F6	Right hand, second digit
T7	Right foot, third digit	F7	Right hand, third digit
T8	Right foot, fourth digit	F8	Right hand, fourth digit
T9	Right foot, fifth digit	F9	Right hand, fifth digit

Affixed Barcode Label(s)
☐ Specimen #1 ☐ Specimen #2 (if applicable)

Please ensure that any ICD-10 codes checked on this requsition form are representative of the patient being seen and their health considerations.