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UROLOGIC PATHOLOGY REQUISITION

Specimen Collection Date: _____

PATIENT INFORMATION			PHYSICIAN INFORMATION					
Patient Name (Last, First, MI)			<div style="text-align: center; font-weight: bold; margin-bottom: 10px;">CLINICAL DIAGRAM (Mark Location of Biopsy(s))</div>					
SSN	DOB	Sex M / F						
Address								
City	State	ZIP						
Patient Insurance Information - Please provide copy of insurance card(s)								
Primary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins. <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill Company			<div style="text-align: center; margin-bottom: 10px;">OTHER</div>					
Policy / ID Number								
Group Number								
Secondary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins. <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill Company								
Policy / ID Number								
Group Number								
DIAGNOSTIC INFORMATION (ICD-9)						TEST ORDERED		
<input checked="" type="checkbox"/> Check All that Apply.		V10.51 Hx. of Bladder Ca.				PROSTATE PATHOLOGY		
188.9 Malig. Neo. of Bldr.		V25.2 Sterilization/Vas.				<input type="checkbox"/> Prostate Histology <input type="checkbox"/> PCA3 Only		
236.5 Prostate Nodule		V10.46 Hx. of Pca				<input type="checkbox"/> Prostate Histology w/Reflex PCA3 if biopsy non-positive		
599.7 Hematuria		Other	OTHER PATHOLOGY					
790.93 Elevated PSA			<input type="checkbox"/> Bladder Histology <input type="checkbox"/> Penile Histology					
CLINICAL & THERAPY HISTORY			<input type="checkbox"/> Testicular Histology-Infertility <input type="checkbox"/> Skin (Specify Site)					
PROSTATE			<input type="checkbox"/> Testicular Histology-Other _____					
<input type="checkbox"/> Last PSA Result _____ Date _____ <input type="checkbox"/> TURP			<input type="checkbox"/> Vas Deferens <input type="checkbox"/> Other _____					
<input type="checkbox"/> D.R.E: Negative <input type="checkbox"/> D.R.E. Suspicious <input type="checkbox"/> Cryosurgery			CYTOLOGY					
<input type="checkbox"/> Hypoechoic Lesion: Suspicious <input type="checkbox"/> Radiation			<input type="checkbox"/> Cytology <input type="checkbox"/> UroVysion FISH Only					
<input type="checkbox"/> Hormone Therapy			<input type="checkbox"/> Cytology w/reflex to UroVysion FISH if Cyto. Non-Neg.					
<input type="checkbox"/> Prior Biopsy: Date: _____			Specimen Collection:					
Result: <input type="checkbox"/> Benign <input type="checkbox"/> Atyp/Susp. <input type="checkbox"/> HGPIN <input type="checkbox"/> Pca			<input type="checkbox"/> Voided Urine					
BLADDER			<input type="checkbox"/> Catheterized Urine					
<input type="checkbox"/> TCC History: Dx Date: _____ Grade: _____			<input type="checkbox"/> Bladder Wash					
<input type="checkbox"/> Hematuria <input type="checkbox"/> TURB			<input type="checkbox"/> Post Cystoscopy Voided Urine					
<input type="checkbox"/> Dysuria <input type="checkbox"/> BCG			<input type="checkbox"/> Illeal Conduit/Neobladder					
<input type="checkbox"/> Proteinuria <input type="checkbox"/> Mitomycin			<input type="checkbox"/> Upper Tract _____					
<input type="checkbox"/> Cystitis <input type="checkbox"/> Thiotepa								
OTHER								

SPECIMEN LABELS The labels found below are for the purpose of identifying the specimen with this requisition. Please affix to the side of each specimen vial you are submitting.

 123456789	LEFT BASE	 123456789	LEFT LATERAL APEX	 123456789	RIGHT LATERAL MID	 123456789	PCA 3 SPECIMEN 2
 123456789	LEFT MID	 123456789	RIGHT BASE	 123456789	RIGHT LATERAL APEX	 123456789	BLADDER
 123456789	LEFT APEX	 123456789	RIGHT MID	 123456789	RIGHT PROSTATE	 123456789	URINE CYTOLOGY
 123456789	LEFT LATERAL BASE	 123456789	RIGHT APEX	 123456789	LEFT PROSTATE	 123456789	UROVYSION FISH
 123456789	LEFT LATERAL MID	 123456789	RIGHT LATERAL BASE	 123456789	PCA 3 SPECIMEN 1	 123456789	

ALL MEDICARE PATIENTS MUST COMPLETE THE FOLLOWING: Medicare will only pay for services determined to be "reasonable and necessary" under section 1662(a) of the Medicare law. If Medicare determines that a particular service is not reasonable and or necessary under Medicare program standards, Medicare will deny payment for that service.

Patient Signature: _____ Date: _____