AVERO™

UROLOGIC PATHOLOGY REQUISITION

Client Services: 1-877-232-9924

PATIENT INFORMATION

Patient Name (Last, First, MI) | Chart#

SSN | DOB | Sex M / F

Address

City | State | ZIP

PHYSICIAN INFORMATION

Provider Signature REQUIRED

PATIENT INSURANCE INFORMATION

Primary Insurance ☐ Medicare ☐ Medicaid ☐ Ins. ☐ Patient ☐ Client Bill

Secondary Insurance ☐ Medicare ☐ Medicaid ☐ Insurance

Did you attach a copy of the Insurance Card (front and back) & Demographic Sheet? ☐ YES INSURANCE NAME & POLICY# HERE

DIAGNOSTIC INFORMATION (ICD-10) Check all that apply

- ☐ **C67.0 Malignant neoplasm-trigone of bladder**
- ☐ **C67.1 Malignant neoplasm-dome of bladder**
- ☐ **C67.2 Malignant neoplasm-lateral wall of bladder**
- ☐ **C67.3 Malignant neoplasm-anterior wall of bladder**
- ☐ **C67.4 Malignant neoplasm-posterior wall of bladder**
- ☐ **C67.5 Malignant neoplasm-bladder neck**
- ☐ **C67.9 Malignant neoplasm-unspecified bladder**
- ☐ **N32.81 Overactive bladder**
- ☐ **N39.46 Mixed incontinence**
- ☐ **N40.0 Enlarged prostate w/o lower urinary tract symp.**
- ☐ **N40.1 Enlarged prostate w lower urinary tract symp.**
- ☐ **N40.2 Nodular prostate w/o lower urinary tract symp.**
- ☐ **N40.3 Nodular prostate w/ lower urinary tract symp.**
- ☐ **R30.0 Dysuria**
- ☐ **R30.9 Painful micturition, unspecified**
- ☐ **R31.0 Gross hematuria**
- ☐ **R31.1 Benign essential microscopic hematuria**
- ☐ **R31.2 Other microscopic hematuria**
- ☐ **R97.2 Elevated prostate specific antigen (PSA)**
- ☐ **Z85.46 Personal Hx of malig. neoplasm of prostate**
- ☐ **Z85.51 Personal Hx of malig. neoplasm of bladder**
- ☐ **Z30.2 Encounter for sterilization**
- ☐ **OTHER:** _____

SPECIMEN INFO: Date Collected (MM/DD/YY) | Time Collected ☐ AM ☐ PM

CLINICAL INFORMATION (Check all that apply)

Prostate Clinical History

Required for Partin Table Prognostic Tool:

Last PSA Result:_____ Date:_____

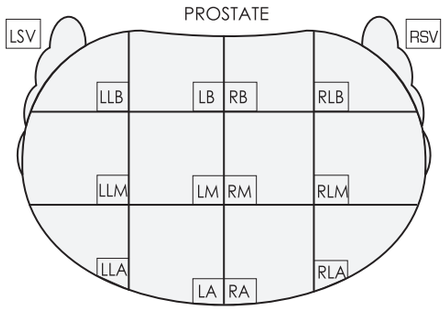
D.R.E: ☐ Normal ☐ Abnormal, Unilateral <50% of Lobe ☐ Abnormal, Bilateral ☐ Abnormal, Unilateral >50% of Lobe

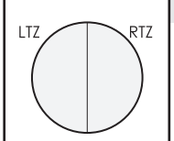
- ☐ Prior Biopsy Result:_____ Date:_____
- ☐ Cryosurgery
- ☐ HIFU
- ☐ Hormone Therapy: _____ Date: _____
- ☐ Radiation ☐ TURP

Bladder & Other Clinical History

- ☐ BCG
- ☐ Cystitis
- ☐ Dysuria
- ☐ Hematuria
- ☐ Mitomycin
- ☐ Proteinuria
- ☐ TCC History:
  Dx Date: _____ Grade: _____
- ☐ Thiotepa ☐ TURB
- ☐ Other _____

TEST ORDERED





OTHER

CYTOLOGY & UROVYSION FISH ○ TECHNICAL PREPARATION ONLY

- ☐ Urine Cytology
- ☐ UroVysion FISH
- ☐ Urine Cytology & UroVysion
- ☐ Urine Cytology w/ reflex UroVysion if Cyto. Atyp. or Suspicious

Specimen Collection

- ○ Voided Urine
- ○ Catheterized Urine
- ○ Illeal Conduit/Neobladder
- ○ Bladder Wash
- ○ Post Cystoscopy Voided Urine
- ○ Upper Tract _____

PROSTATE PATHOLOGY ○ TECHNICAL PREPARATION ONLY

- ☐ Prostate Histology
- ☐ Progensa PCA3 Test

OTHER PATHOLOGY ○ TECHNICAL PREPARATION ONLY

- ☐ Bladder
- ☐ Penile Histology
- ☐ Skin _____
- ☐ Testicular-Infertility
- ☐ Vas Deferens
- ☐ Other _____
- ☐ Testicular-Other

CLINICAL AND OTHER PATHOLOGY*

- ☐ PSA
- ☐ PSA - Free and Total
- ☐ Testosterone
- ☐ Testosterone Free & Bio-available w/SHBG
- ☐ SHBG
- ☐ Estradiol
- ☐ Prolactin
- ☐ Kidney Stone
- ☐ Bladder Stone
- ☐ Urine Culture & Sensitivity
- ☐ 24 Hour Urine
- ☐ Other _____

AV-23039-01 REV 032018

Physician Notice(s): 1)If your signature is not affixed hereto, you attest you have caused the subject patient's Medical record to include a specific reference(i.e.,order)to your intent that the accompanying specimen(s) be examined by a pathologist, and you have record of the signed order in the patients Medical Record. 2)Medicare will only pay for medical testing supported by a symptomatic diagnosis.

UR000000 Name Left Lat Base	UR000000 Name Left Base	UR000000 Name Right Base	UR000000 Name Right Lat Base	UR000000 Name Urine Cytology
UR000000 Name Left Lat Mid	UR000000 Name Left Mid	UR000000 Name Right Mid	UR000000 Name Right Lat Mid	UR000000 Name UroVysion FISH
UR000000 Name Left Lat Apex	UR000000 Name Left Apex	UR000000 Name Right Apex	UR000000 Name Right Lat Apex	UR000000 Name Bladder
UR000000 Name L Seminal Ves.	UR000000 Name Left Prostate	UR000000 Name Right Prostate	UR000000 Name R Seminal Ves.	UR000000 Name Testicle
UR000000 Name L Trans Zone	UR000000 Name _____	UR000000 Name _____	UR000000 Name R Trans Zone	UR000000 Name Vas Deferens 1
UR000000 Name PCA3 Spec. 1	UR000000 Name PCA3 Spec. 2	UR000000 Name PCA3 Spec. 3	UR000000 Name PCA3 Spec. 4	UR000000 Name Vas Deferens 2

AVERO COPY