

# UROLOGY REQUISITION

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ACCOUNT INFORMATION				PATIENT INFORMATION			
Client Name				Patient Name (Last, First, MI)			
Street Address 1				Street Address 1			
Street Address 2				Street Address 2			
City		State		City		State	
Zip				City		State	
Telephone No. ( ) ( ) ( )		Fax No. ( ) ( ) ( )		Home Telephone No. ( ) ( ) ( )		Work Telephone No. ( ) ( ) ( )	
Ordering Physician / Pathologist		NPI		Race		Date of Birth	
Treating Physician		NPI		Social Security No.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
						Chart no. / Patient ID No. (Optional)	
BILLING INFORMATION (Attach demographics and front and back of insurance card)							
<b>Bill:</b> <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Medicare / Medicaid <input type="checkbox"/> Client / Facility <b>Patient Status:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient				Group Employer Name		Policy No.	Group No.
Primary Insurance Co. Name <input type="checkbox"/> Information Attached				Policy Holder Name		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address				Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
City	State	Zip	Telephone No. ( ) ( ) ( )	Secondary Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please attach)			
<p><b>*Medicare patients must review and sign the separate Advanced Beneficiary Notice for services that may not meet Medicare's medical necessity or frequency limitation.</b></p>							
PROSTATE			URINARY BLADDER / URINE			OTHER HISTOLOGY	
<b>CLINICAL DIAGNOSIS</b> <input type="checkbox"/> Elevated PSA (790.93) <input type="checkbox"/> Prostate Cancer (185) <input type="checkbox"/> Abnormal DRE (236.5) <input type="checkbox"/> BPH (600.00) <input type="checkbox"/> Other _____			<b>CLINICAL DIAGNOSIS</b> <input type="checkbox"/> Hematuria (599.7) <input type="checkbox"/> Bladder Cancer (188.9) <input type="checkbox"/> Bladder, Uncertain Behavior (236.7) <input type="checkbox"/> Other _____			<b>CLINICAL DIAGNOSIS</b> <input type="checkbox"/> Sterilization (V25.2) <input type="checkbox"/> Phimosis (605) <input type="checkbox"/> Balanoposthitis (607.1) <input type="checkbox"/> Hydrocele (603.9) <input type="checkbox"/> Spermatocoele (608.1) <input type="checkbox"/> Varicocele (456.4) <input type="checkbox"/> Other _____	
<b>HISTORY</b> <b>Required for Prostate BioStrat™ Assay</b> PSA _____ ng/dL Date _____ Digital Rectal Examination: <input type="checkbox"/> Normal Abnormal <input type="checkbox"/> Unilateral < ½ Lobe <input type="checkbox"/> Unilateral > ½ Lobe <input type="checkbox"/> Bilateral			<b>HISTORY</b> <b>Required for Bladder BioStrat™ Assay</b> Prior Recurrence Rate: <input type="checkbox"/> Primary Recurrent: <input type="checkbox"/> ≤1/yr <input type="checkbox"/> >1/yr Tumor Category: <input type="checkbox"/> Ta <input type="checkbox"/> T1 Number of Tumors: <input type="checkbox"/> 1 <input type="checkbox"/> 2-7 <input type="checkbox"/> ≥8 Grade (WHO 1973): <input type="checkbox"/> G1 <input type="checkbox"/> G2 <input type="checkbox"/> G3 Tumor Diameter: <input type="checkbox"/> <3 cm <input type="checkbox"/> ≥3 cm Concomitant CIS: <input type="checkbox"/> No <input type="checkbox"/> Yes Cystoscopy: <input type="checkbox"/> NA <input type="checkbox"/> Neg <input type="checkbox"/> Susp <input type="checkbox"/> Pos Cytology: <input type="checkbox"/> Unsat <input type="checkbox"/> Neg <input type="checkbox"/> Atyp <input type="checkbox"/> Pos			<b>HISTORY</b> <input type="checkbox"/> Other	
<b>Previous Therapy</b> <input type="checkbox"/> None <input type="checkbox"/> Hormonal <input type="checkbox"/> XRT <input type="checkbox"/> Cryotherapy <input type="checkbox"/> HIFU <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____			<b>Specimen Source</b> <input type="checkbox"/> Voided Urine <input type="checkbox"/> Cath Urine <input type="checkbox"/> Bladder Wash <input type="checkbox"/> Urethra Wash <input type="checkbox"/> Conduit <input type="checkbox"/> Neobladder Ureteral <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. Renal <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. <input type="checkbox"/> Other _____				
<b>TEST REQUESTED</b> <input type="checkbox"/> Prostate Biopsy <input type="checkbox"/> Seminal Vesicles <input type="checkbox"/> PCA3 <input type="checkbox"/> PCA3 (Reflex) <input type="checkbox"/> Prostate BioStrat™ (Reflex) <input type="checkbox"/> Circulating Tumor Cell (CTC) Metastatic Prostate Ca <input type="checkbox"/> Other _____			<b>TEST REQUESTED</b> <input type="checkbox"/> Cytology <input type="checkbox"/> Bladder Biopsy <input type="checkbox"/> Cyto w/ UroVysion FISH <input type="checkbox"/> UroVysion FISH (Reflex) <input type="checkbox"/> Bladder BioStrat™ (Reflex) <input type="checkbox"/> Other _____			<b>TEST REQUESTED</b> Vas Deferens <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. <input type="checkbox"/> Both <input type="checkbox"/> Foreskin <input type="checkbox"/> Hydrocele <input type="checkbox"/> Consultation (Referred Slides) <input type="checkbox"/> Other _____	
Collection Date _____			Collection Date _____			Collection Date _____	
Collection Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			Collection Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			Collection Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
# Vials / Containers Submitted _____			# Vials / Containers Submitted _____			# Vials / Containers Submitted _____	