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UROLOGY REQUISITION FORM

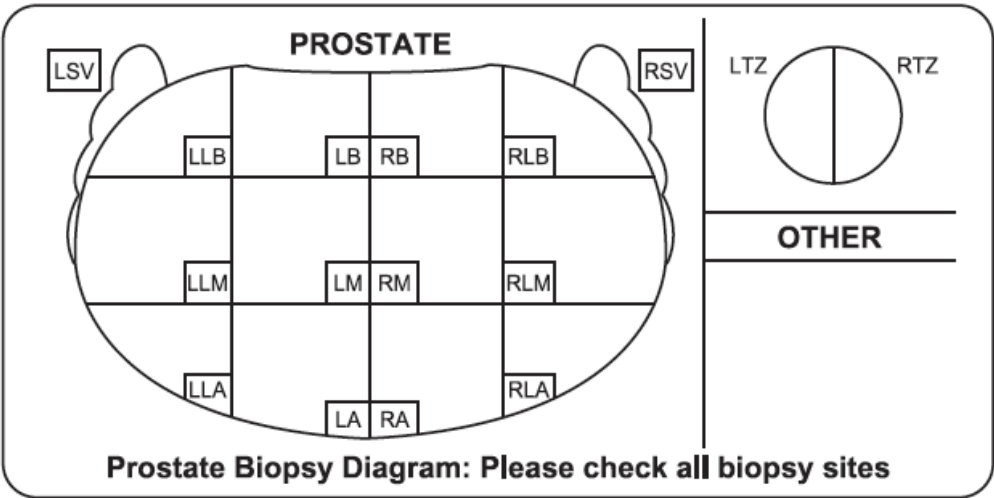
EIN: 20-4506043 | CLIA: 10D1055514

Physician Information
Copy To
Fax

Insurance Information
Bill Insurance
Bill Client
Medicare Number
Primary Insurance
City
State
Zip
Policy #
Group/Plan #
Group Employer
Name of Policy Holder
Phone
Policy #
Group #
Group Employer
Name of Policy Holder

Patient Information
Last
First
MI
DOB
Last 4 of SSN
Address
City
State
ZIP
Phone

Diagnostic information (ICD10) check all that apply
185 Malig. Neo. of Prostate
790.93 Elevated PSA
187.8 Malig. Neo. of Male Genital
V10.51 Hx of Bladder Ca.
188.9 Malig. Neo. of Bladder
V25.2 Sterilization Vas.
599.7 Hematuria
V10.46 Hx of Prostate Ca.
600.0 Hypertrophy (Benign) of Pros.
Other:
600.1 Nodular Prostate



Clinical Information
Prostate:
Last PSA Result
Date:
D.R.E: Suspicious
Hypoechoic Lesion: Suspicious
Prior Biopsy: Date
Benign
Atyp/Susp
HGPIN
Prostate CA
Radiation
TURP
Hormone Rx
Cryosurgery
Bladder:
TCC History: Dx Date:
Hematuria
Dysuria
Proteinuria
Cystitis
TURB
BCG
Mitomycin
Thiotepa
Other:

Name of Person Completing From
Date of Procedure

Test Ordered Perform approved reflexive testing as medically necessary

Prostate Pathology:
Prostate Histology (see diagram 1)
Reflex to PCA3 if biopsy is negative

Bladder Pathology:
Bladder Biopsy:
Biopsy Site 1
Biopsy Site 2
Biopsy Site 3
Biopsy Site 4

Cytology / UroVysion (FISH):
UroVysion FISH Only
Urine Cytology + UroVysion FISH
Urine Cytology (reflex to UroVysion if necessary)

Specimen Collection:
Voided Urine
Cath. Urine
Ileal Conduit
Bladder Wash
Upper Tract

Other Pathology:
Penile Histology
Testicular Histology-Infertility
Vas Deferens
Skin, Specify Site
Other