Uropathology Requisition Form

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LAB USE ONLY

UP 1001

CLIENT INFORMATION

Patient Last Name | First Name | MI | DOB MM/DD/YEAR | Age | Sex ☐M ☐F | Social Security # – –

Patient Home Address | Apt.# | City | State | Zip | Home Phone ( ) -- | Alternative Phone ( ) --

Bill To: ☐ Client ☐ Patient ☐ Insurance ☐ Medicare (ABN) signed ☐ Medi-Cal (Attach POE) ☐ Work Comp ☐ HMO/IPA Authorization Number: _____

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other _____

Primary Ins. Name _____ ID# _____ Group # _____

Secondary Ins. Name _____ ID# _____ Group # _____

Employer's Name _____ City _____ Tel ( ) -

Please attach front and back copies of insurance card(s).

Patient's Reference ID:

Ordering Physician's Name:

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDI-CAL (MEDICAID) REIMBURSEMENT IS SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT, RATHER THAN FOR SCREENING PURPOSES.

CLINICAL INFORMATION

PROSTATE

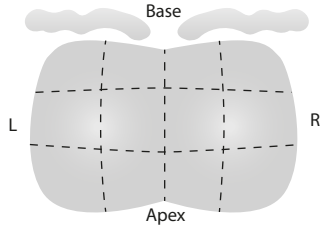
PREVIOUS BIOPSY
☐ None
☐ Benign
☐ Carcinoma
☐ High Grd PIN
☐ Suspicious
DX Date: ____/____/____
☐ Other _____

PAST TREATMENT
☐ Prostatectomy
☐ Hormonal Block
☐ Radiation
☐ Chemotherapy
☐ TURP

DRE FINDINGS
☐ Normal
☐ T1a ☐ T2a ☐ T3a ☐ T4a
☐ T1b ☐ T2b ☐ T3b ☐ T4b
☐ T1c ☐ T2c ☐ T3c

Last Total PSA: ____ng/ml Last Free PSA: ____ ng/ml Date: ____/____/____

Indicate Palpable Leisions



☐ Firm ☐ Hard ☐ Single Nodule ☐ Mult. Nodules

URINE / BLADDER

HISTORY
☐ Hematuria
☐ Calculi
☐ Urothelial Carcinoma
Grade: _____ _____

TREATMENT
☐ TURBT
☐ Mitomycin
☐ BCG
☐ Thiotepa
☐ Cystectomy
☐ Radiation

☐ Other _____

BX INDICATION ☐ Surveillance ☐ Elevated PSA ☐ Mass/Abnormal DRE ☐ Other _____

SPECIMEN INFORMATION

SPECIMEN TYPE
☐ Prostate Biopsy ☐ Bladder Biopsy
☐ Urine Cytology ☐ Uro Vysion™
☐ Second Opinion ☐ Vas Deferens
☐ Other _____

URINE CYTOLOGY / SPECIMEN TYPE
1st Void: ☐ Voided Urine ☐ Catheterized Urine
☐ Yes ☐ No
☐ Post Cysto Void ☐ Ileal Conduit
☐ Clean Catch ☐ Renal Wash ☐ Bladder Wash
☐ Left ☐ Right
Fixative Used: _____
☐ Other: _____

STONE ANALYSIS

SPECIMEN SOURCE:
☐ Ureter ☐ Bladder ☐ Kidney

SPECIMEN OBTAINED:
☐ Lithotripsy ☐ Spontaneously Passed ☐ Surgically Removed

Collec. Date: ____/____/____ Time: ____:____ # of Vials: ____

ICD-9 DIAGNOSTIC CODE MUST BE PROVIDED FOR EACH TEST

CONSULTATION

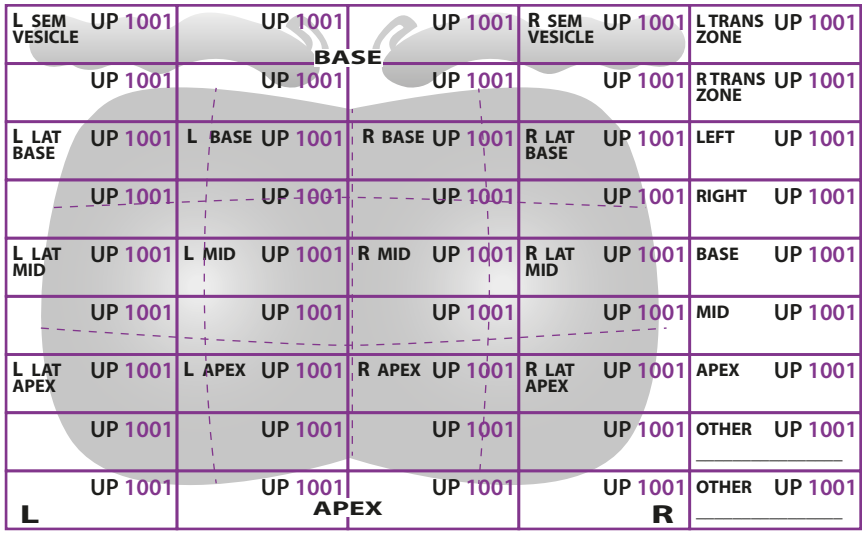
☐ Comprehensive Diagnostic Consultation Number of Slides: ____

ADDITIONAL TEST REQUESTS / INFORMATION / INSTRUCTIONS

*Additional testing may be performed if determined to be medically necessary to render a diagnosis in the opinion of the reviewing pathologist at additional cost.

SPECIMEN LABELLING

Remove the appropriate Labels and Attach TO THE SIDE (not top) of Specimen Containers.



Physician's Signature: _____ **Date:** ____/____/____

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* Beneficiary's signature is required on reverse side.