UroPath DIAGNOSTICS

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BIOPSY & CYTOLOGY REQUISITION

CLIENT INFORMATION

Requesting Physician	Patient Chart # (MRN)
Referring Physician	Referring Fax

PATIENT INFORMATION

First Name	Last Name	MI	Date of Service
Mailing Address			
City	State	ZIP	
DOB	Social Security #	Race	
Gender	Home Phone		

Bill to: ❏ Client ❏ Insurance ❏ Medicaid ❏ Medicare ❏ Patient

PRIMARY INSURANCE INFORMATION

Insurance Company Name	Insurance Company Phone
Insurance Company Address	
Policy ID#	Group #
Insured's Name	
Relation to Patient	Insured's DOB

SECONDARY INSURANCE INFORMATION

Insurance Company Name	Insurance Company Phone
Insurance Company Address	
Policy ID#	Group #
Insured's Name	
Relation to Patient	Insured's DOB

DIAGNOSTIC & CLINICAL INFORMATION

❏ 790.93 Elevated PSA
❏ 185 Malignant Neoplasm of Prostate
❏ 600.01 Hypertrophy (benign) of prostate with urinary obstruction
❏ 600.10 Prostate Nodule
❏ 236.5 Neoplasm of uncertain behavior of prostate
❏ 236.7 Neoplasm of uncertain behavior, Bladder
❏ 10.46 History of Prostate Cancer
❏ V16.42 Family History of Prostate Cancer
❏ V25.2 Sterilization, Vas
❏ Other:________________________

❏ 599.70 Hematuria, unspecified
❏ 599.71 Gross Hematuria
❏ 599.72 Microscopic Hematuria
❏ 188.9 Malignant Neoplasm of Bladder
❏ 233.7 Carcinoma in situ (CIS), Bladder
❏ V10.51 History of Bladder Cancer
❏ V16.52 Family History of Bladder Cancer
❏ Other:________________________

HISTOLOGY

❏ Prostate Biopsy ❏ Bladder Biopsy ❏ Vas Deferens
❏ Reflex PTEN and TMPRSS2:ERG FISH on malignant prostate biopsy
❏ Reflex PTEN deletion FISH on malignant prostate biopsy
❏ Reflex TMPRSS2:ERG Fusion FISH on malignant prostate biopsy
❏ Other____

All cases are assumed Global. If Not Global, please indicate:
❏ **Slide Process Only (TC)** ❏ **Interpretation Only (PC)** ❏ Second Opinion

CYTOLOGY

All cases are assumed Global. If Not Global, please indicate:
❏ Urine Cytology
❏ **Slide Process Only (TC)** ❏ **Interpretation Only (PC)**
❏ Bladder FISH if Atypical/Suspicious Cytology
❏ Bladder FISH (Bladder Cancer)

SPECIMEN SOURCE:
❏ Voided Urine ❏ Cath Urine ❏ PostCysto Void ❏ Ileal Conduit ❏ Bladder Wash
❏ Clean Catch ❏ Other_____________________________

HISTORY:
❏ History of Bladder Carcinoma ❏ Other_____________________________

TREATMENT:
❏ Resection ❏ Chemotherapy ❏ Radiation ❏ BCG ❏ Ileal Conduit/Neobladder

MOLECULAR

❏ CT/NG ❏ Chlamydia ❏ Gonorrhoeae

SPECIMEN SOURCE: ❏ Voided Urine ❏ Cath Urine ❏ Clean Catch

❏ PCA3 (Add 2.5 mL of urine to each of two GEN-PROBE PROGENSA PCA3 Urine Specimen Transport Tubes) __________ng/mL (Enter PSA result)

BIOPSY - PLEASE INDICATE INDIVIDUAL SPECIMEN(S)*

BASE

❏ LSV (O) ❏ LTZ (M)

❏ LLB (G)	❏ LB (A)	❏ RB (D)	❏ RLB (J)
❏ LLM (H)	❏ LM (B)	❏ RM (E)	❏ RLM (K)
❏ LLA (I)	❏ LA (C)	❏ RA (F)	❏ RLA (L)

APEX

❏ RTZ (N) ❏ RSV (P)

Total # of Prostate jars submitted: ____________

Other site(s)____ Biopsy Date____/____/______

*Each separately indicated site will receive its own diagnosis (and be billed accordingly). If sites are not separately indicated, one diagnosis will be given to the content of each vial.
Please fill out pre-authorization form, if required.

AUTHORIZATION TO FILE CLAIM(S)

I hereby authorize the release of any information for this service to Poplar Healthcare. I authorize the release of any medical information necessary to process a claim and request payment of any medical insurance benefits to Poplar Healthcare. I understand that I am responsible for any amount not reimbursed by insurance. Poplar Healthcare or any of its affiliate has my consent to use my specimen for research not directly related to my treatment. If this research results in commercial remuneration, I relinquish any and all rights I may have with my specimen regarding such remuneration.

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Patient/Responsible Party Signature (REQUIRED)