



Associated Pathology Medical Group

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STONE DIAGNOSTIC REQUISITION

PATIENT INFORMATION			CLIENT INFORMATION		
Last Name		First Name	M.I.		
Date of Birth	Sex M F	Date Specimen Collected ____/____/____			
Patient Social Security Number		Patient Phone Number			
Street Address			Apt. #		
City		State	Zip		
Special Handling <input type="checkbox"/> Phone <input type="checkbox"/> Fax (____) _____ <input type="checkbox"/> CC _____					

BILLING INFORMATION <small>Attach copy of all insurance I.D. cards (front and back, please)</small>	
Bill To: <input type="checkbox"/> Patient <input type="checkbox"/> Doctor <input type="checkbox"/> HMO <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare/Medi-Cal # _____	
Subscriber Name	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____
Insurance Name	Address _____ City, State, Zip _____
ID #	Group #
Subscriber DOB:	Subscriber Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medicare patient reviewed and signed advanced beneficiary notice for non-covered services	

Diagnosis Code(s) _____

URINE ANALYSIS REQUESTED <small>(See Tables 1-4 on reverse for individual components of each profile)</small>	STONE ANALYSIS REQUESTED <small>(See Tables 5 and 6 on reverse)</small>
CUSTOM 24-HOUR URINE PROFILE <input type="checkbox"/> StoneRisk® Diagnostic Profile <input type="checkbox"/> UroRisk® Diagnostic Profile <input type="checkbox"/> StoneTrack® Diagnostic Test <input type="checkbox"/> StoneRisk® Cystine Diagnostic Test	SELECT ONE OF THE FOLLOWING: <input type="checkbox"/> StoneComp® You will be billed for the test that provides the definitive results, either Infrared Spectroscopy or X-ray Diffraction (see Table 5 on reverse). ICD-9 CODE(s) (required) _____ SPECIMEN OBTAINED: <input type="checkbox"/> Spontaneously passed <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Surgically removed COLLECTION DATE: _____ STONE LOCATION: _____
ICD-9 CODE(S) (required) _____ PATIENT WEIGHT (required) _____ 24-Hour Urine Specimen Completed: Date ____/____/____	(To be completed by referring lab if applicable) LAB INFORMATION ACESSION #: _____ DATE ACCESSIONED: _____ BY: _____
THE PATIENT IS CURRENTLY TAKING: (Certain medications may result in elevated analytical values) <input type="checkbox"/> Vit C Dose: _____ <input type="checkbox"/> Lithium Dose: _____ <input type="checkbox"/> Calcium Dose: _____ <input type="checkbox"/> Magnesium Dose: _____ <input type="checkbox"/> Creatine Dose: _____	LIST THE CURRENTLY PRESCRIBED DRUG THERAPY: (Necessary for tracking effectiveness of therapy) <input type="checkbox"/> RX: _____ Dose: _____ Date started: _____ <input type="checkbox"/> RX: _____ Dose: _____ Date started: _____ <input type="checkbox"/> RX: _____ Dose: _____ Date started: _____
URINE ANALYSIS PHYSICIAN ACKNOWLEDGEMENT: I have reviewed the individual/groups of tests offered by APMG listed in the tables on the reverse of this form. I hereby request that APMG perform the test(s) on the reverse side of this form, annotated with an ICD-9-CM code, as a customized profile. I understand that (1) it is my responsibility to have the entire patient file and to provide to APMG written documentation (including ICD 9 codes, especially where required by an LMRP) to support the medical necessity for each test included in each profile ordered; (2) it is my responsibility to tailor these tests to the minimal diagnostic/treatment needs of this patient and to order only the lesser inclusive customized profile which best supports diagnosis/management of this patient; (3) all of the tests are performed on urine specimens and will not be billed as a single profile amount, except that claims submitted for reimbursement under the Medicare and Medicaid programs will be by individual CPT code—the amount of reimbursement under Medicare or Medicaid varies by state and is provided by APMG in the Explanation of Medicare/Medicaid Reimbursement through sales personnel or upon request; (4) the DHHS Office of the Inspector General takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions and remedies available under civil, criminal or administrative law; (5) the patient signature is on file authorizing release of information and assignment of payment to APMG; and (6) I have read and understand the "NOTICE TO PHYSICIAN" on the reverse side. X _____ Physician/Authorized Provider Signature (required) Date: _____	
FOR MISSION USE ONLY ORD#: _____ PT#: _____ ABIL: _____ REF.DIR.: _____	