



Associated Pathology Medical Group

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**UROLOGIC PATHOLOGY
REQUISITION**
Histology/Cytology

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
 Phone Fax (____) _____ CC _____ Physician's Signature _____

BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)

Bill To: Patient Doctor HMO Insurance Medicare/Medi-Cal # _____

Subscriber Name _____ Relationship to Subscriber: Self Spouse Dependent Other _____

Insurance Name _____ Address _____ City, State, Zip _____

ID # _____ Group # _____

Subscriber DOB: _____ Subscriber Sex: Male Female

Medicare patient reviewed and signed advanced beneficiary notice for non-covered services

Diagnosis Code(s)

HISTOLOGY

Test(s) required. Please check box.

Tissue type: _____

Prostate histology only

Prostate histology with DNA image analysis (when indicated)

Bladder histology

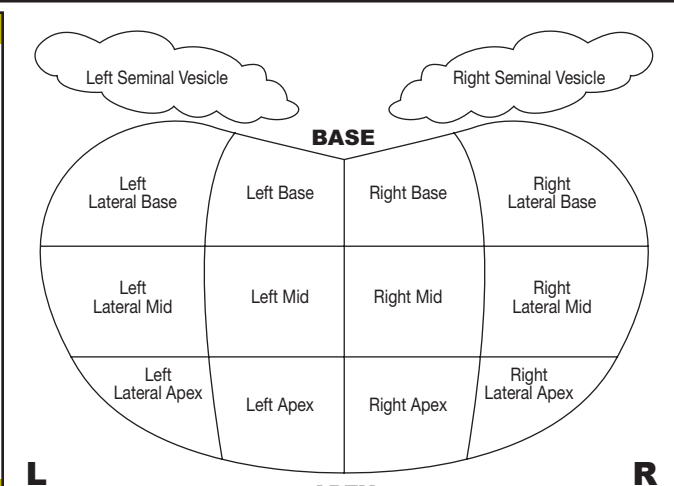
Bladder histology with DNA image analysis (when indicated)

Vas deferens

#1 R or L #2 R or L

Second Opinion _____

Other _____



CYTOLOGY

Test(s) required. Please check box.

Urine cytology

UroVysion™ FISH

Immunocyt™ (includes cytology)

Other _____

Specimen Type/Volume _____ ml

VU (voided urine) CU (catheritized urine)

BW (bladder wash) PCV (post cysto voided)

Renal wash L _____ R _____

Uretal wash L _____ R _____

Neo bladder _____ urine)

Other _____

CLINICAL INFORMATION

PSA _____ ng/ml Date _____

DRE: Normal Abnormal

Abnormal findings: _____

Previous biopsy: None Benign Inflammation

Atypia HPIN Malignant

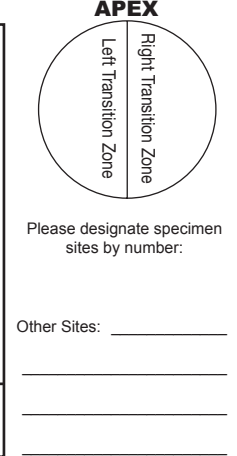
Other _____

Previous therapy: None Hormonal BCG

Radiation Chemotherapy Cyrosurgery

Surgery Other _____

Date & Time Specimen Collected _____ By _____



CLINICAL INFORMATION

Cystoscopy: Normal Abnormal

Abnormal findings: _____

Previous cytology exam: Date _____

None Benign Atypia Malignant Dysplasia

Other _____

Previous therapy:

None BCG Radiation Chemotherapy Surgery

Other _____

Date & Time Specimen Collected _____ By _____

ADDITIONAL CLINICAL INFORMATION