Associated Pathology Medical Group

APMG

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UROLOGIC PATHOLOGY REQUISITION
Histology/Cytology

PATIENT INFORMATION

Last Name | **First Name** | **M.I.**

Date of Birth / / | **Specimen Date** / / | **Sex** M F | **MRN #**

Patient Social Security Number | **Patient Phone Number**

Street Address | **Apt. #**

City | **State** | **Zip**

CLIENT INFORMATION

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

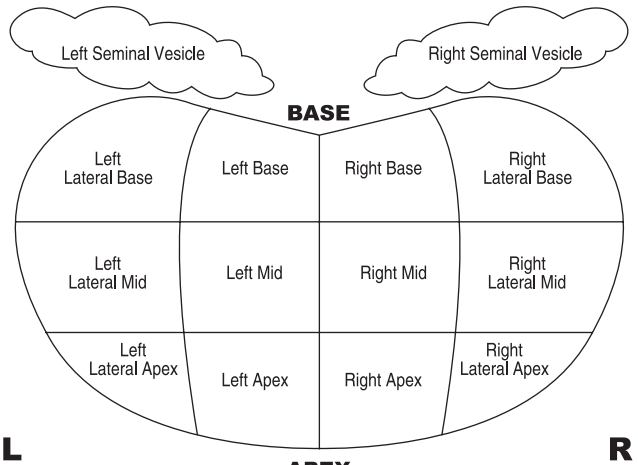
○ Bladder histology

○ Vas deferens

○ #1 R or L ○ #2 R or L

○ Second Opinion _____

○ Other _____



Please designate specimen sites by number:

Other Sites: _____

CYTOLOGY

Test(s) required. Please check box.

○ Urine cytology

○ UroVysion™ FISH

○ Other _____

Specimen Type/Volume _____ **ml**

○ VU (voided urine) ○ CU (catheritized urine)

○ BW (bladder wash) ○ PCV (post cysto voided urine)

○ Renal wash L _____ R _____

○ Uretal wash L _____ R _____

○ Neo bladder

○ 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 ○ Cryosurgery

○ 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

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