INTEGRATED PATHOLOGY

SCIENTIFIC DIAGNOSES AND LABORATORY SOLUTIONS

UROLOGY PATHOLOGY REQUISITION

RESET FORM

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Prostate Cancer Awareness

CLIENT INFORMATION:

PATIENT INFORMATION

Patient Name: _____ (LAST, FIRST)
DOB: _____ Age: _____ Gender: ◯ Male ◯ Female
Street Address: _____
City: _____ State: _____ Zip Code: _____
Patient ID #: _____ SSN#: _____
Submitting Physician: _____
Patient Phone #: _____ Referring Physician: _____
Date of Collection: _____ Time of Collection: _____

BILLING INFORMATION

Please provide the current ICD-10 code(s): _____
Please complete billing information below or attach a separate sheet and a copy of insurance card with the necessary information:
Insurance Company State Name of Employer
_____
Policy No. Group No.
_____
Insurance Company Street Address City State Zip Code
_____
Name of Insured (if other than patient): _____
Patient's relationship to insured: ◯ Spouse ◯ Child ◯ Other, Explain
IP Pathologists may order additional testing based on medical necessity.

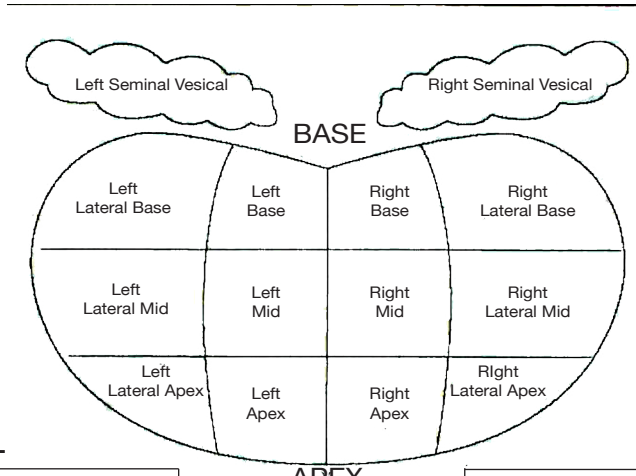
CLINICAL INFORMATION

HISTOLOGY

Test(s) required. Please check box.

Tissue type: _____

- ☐ Prostate Histology only
- ☐ Bladder Histology
- ☐ Ureter
- ☐ Vas Deferens
  - ☐ #1 R or L ☐ #2 R or L
- ☐ Skin _____
- ☐ Other _____



L R

Please designate specimen sites by number:

Other Sites: _____

CYTOLOGY

Test(s) required. Please check box.

- ☐ Urine Cytology
- ☐ _____
- ☐ _____
- ☐ _____

Specimen Type/ Volume _____ ml

- ☐ VU (voided urine) ☐ CU (cathertized urine)
- ☐ BU (bladder wash) PCV (post cysto voided urine)
- ☐ Renal Wash L ☐ R ☐
- ☐ Ureteral Wash L ☐ R ☐
- ☐ Neo Bladder
- ☐ Barbotage
- ☐ Other

PSA

PSA _____ NG/uL 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 Specimin Collected	By

CYTOLOGY

Cystoscopy: ☐ Noormal ☐ Abnormal
Abnormal findings:
Previous Cytology Exam: Date
☐ None ☐ Benigh ☐ Atypia ☐ Malignant ☐ Dysplasia
☐ Other
Previous Therapy:
☐ None ☐ BCG ☐ Radiation ☐ Chemotherapy
☐ Surgery ☐ Other

Date & Time Specimen Collected	By

SPECIAL INSTRUCTIONS & ADDITIONAL NOTES

IPS USE ONLY: Received Date & Time: Assigned Case #: