Southern Pathology

Knowledge from people who care

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NEXT VISIT TO PHYSICIAN: / / (mm/dd/yy)

LAB. NUMBER:

UROPATHOLOGY REQUISITION

PATIENT INFORMATION

Patient Name: _____ Age: _____

Gender: ○F ○M DOB: ___/___/___ (mm/dd/yy) SS No.: XXX-XX-_____ Phone No: (___) ___-_____

Postal Address: _____

Med Record No.: _____

ORDERING PHYSICIAN

Physician Name: _____

Address: _____

Phone No: _____

Physician Signature: _____

BILLING INFORMATION (Please provide copy of insurance card)

Bill to: ○Client ○Insurance ○Patient

Health Insurance: _____

Insurance Contract No.: _____ Group No.: _____

CLINICAL INFORMATION

PSA: _____ NG/ul _____%F/T Date: ___/___/___ (mm/dd/yy)

DRE: ○Normal ○Abnormal _____ Location

Abnormal Findings: _____

PREVIOUS BIOPSY:

○None ○Benign ○Inflammation ○Atypia ○HPIN ○Malignant

○Other: _____

CYSTOSCOPY: _____ ○Normal ○Abnormal

PREVIOUS CYTOLOGY EXAM: Date: ___/___/___ (mm/dd/yy)

○None ○Benign ○Atypia ○Dysplasia ○Malignant

○Other: _____

PREVIOUS THERAPY: Date: ___/___/___ (mm/dd/yy)

○None ○BCG ○Radiation ○Chemotherapy ○Surgery

○Other: _____

CYTOLOGY

ICD-9/10 Codes or Diagnosis: _____

Collection Date & Time: Sample 1: _____

Sample 2: _____ Sample 3: _____

TEST REQUEST:

○Urine Cytology x1 / x2 / x3 ○Urine Cytology ***reflex*** to UroVysion FISH

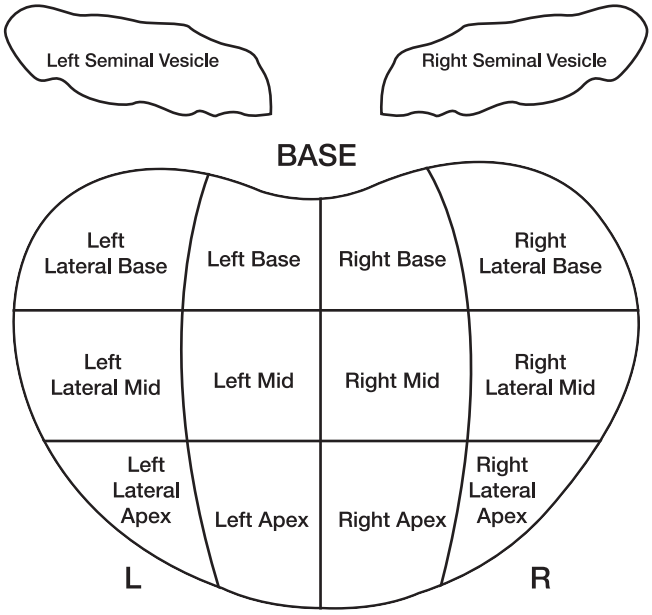
○UroVysion FISH ○Other Test: _____

COLLECTION METHOD:

○Voided Urine ○Bladder Wash ○Catheterized Urine

○Renal Wash L___ R___ ○Urethral Wash L___ R___

○Other Test: _____



HISTOLOGY

ICD-9/10 Codes or Diagnosis: _____

Collection Date: ___/___/___ (mm/dd/yy) Time: _____

 # Containers: ○6 ○12 ○Other: _____

 # Cores Submitted: _____

TEST REQUEST:

○Prostate Histology

○PCA3 Plus (Urine)

○Vasectomy Histology

○Bladder Histology

○Expert Prostate Slide Consultation

○OTHER TEST: _____

Yo autorizo a mi médico a proveer información a Southern Pathology Services para propósitos de facturación a mi plan médico. De mi plan médico no cubrir la(s) prueba(s) de patología, me hago responsable del costo ya sea del deducible o el costo total de la(s) prueba(s).

I authorize my physician to provide information to Southern Pathology Services for billing purposes to my Medical Insurance Plan. I will be responsible for the deductible or total cost of test(s) if my medical insurance determines it is a non-covered service.

Patient Signature: _____ **Date:** (mm/dd/yy) _____

www.southernpathology.com