Inform Diagnostics Urologic Pathology Requisition

10000

Inform Diagnostics observes all standing orders for clients that have signed an Advanced Protocols Form.

PATIENT INFORMATION Shaded fields are required

Last Name	First Name	MI
Street Address		Apt #
City	State	Zip
Patient Phone #	Patient Work Phone #	
Patient Social Security #	Patient Medical Record #	
Date of Birth / /	Age	Sex

ANCESTRY *Check all that apply*

❍ White/Caucasian (specify region) ❍ Western/Northern Europe ❍ Central/Eastern European ❍ Ashkenazi Jewish ❍ Native American
❍ Hispanic/Latino ❍ Black/African-American ❍ Asian ❍ Middle Eastern ❍ Pacific Islander ❍ Other _____

BILLING INFORMATION

Complete billing information on reverse side or attach copy of front and back of patient's card. We file all primary and secondary insurance plans if information is provided.

COLLECTION INFORMATION & HISTORY

Date of Collection	Time of Collection	Clinical History
/ /	_____ AM _____ PM	

PROSTATE

Please add ICD-10 trailing digits on blank lines below.

❍ Prostate Nodule D40.0_____ ❍ Hx. of Prostate Cancer Z85.46/C61_____
❍ Elevated PSA R97.2_____

Required for Han & Partin Tables*:

*Pre-Biopsy PSA Result: _____

*DRE *(for clinical stage info if biopsy is positive)*:

❍ Normal (T1c) ❍ Abnormal, Unilateral ≤ 50% of lobe (T2a)
❍ Abnormal, Bilateral (T2c) ❍ Abnormal, Unilateral > 50% of lobe (T2b)

Prior Bx Findings: _____ ❍ PCA3: _____

Prior Rx: ❍ Hormone Therapy ❍ Radiation ❍ Cryosurgery

Age at Diagnosis: _____

DIAGNOSTIC TEST ORDER — Mark Location of Biopsy(s)

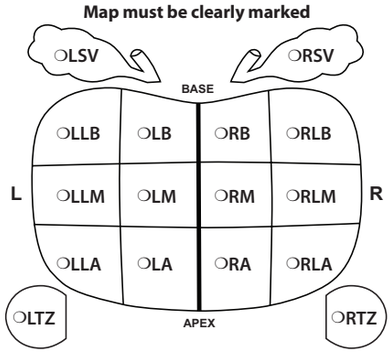
❍ Diagnostic Prostate Biopsy ❍ TURP ❍ Saturation Biopsy
☐ **PINgenius** reflex for HGPIN
☐ *Confirm* **MDx** reflex for: ☐ Negative ☐ HGPIN

❍ Prognostic Panel for Localized Prostate Cancer
☐ **PTEN/ERG** ☐ *oncotype* DX ☐ **Decipher** ☐ Prolaris
☐ All Gleason grades ☐ 3+3 ☐ 3+4 ☐ 4+3 ☐ ≥8

❍ know error
For core with highest grade: ☐ Unilateral ☐ Bilateral

Signature Required† _____

Map must be clearly marked



REQUIRED

Total # of ***PROSTATE*** jars submitted: ☐

REQUIRED *for laboratory accessioning purposes*

❍ Other:

BLADDER, URINE CYTOLOGY, FISH

Please add ICD-10 trailing digits on blank lines below.

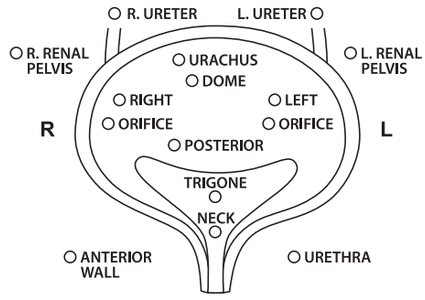
❍ Hematuria R319_____ ❍ Cystitis N30.90 with hematuria
❍ Cystitis N30.91 without hematuria
❍ Hx. of Bladder Ca. Z85.51_____:
☐ TCC: High Grd ☐ TCC: Low Grd ☐ CIS

Prior Bx Findings: _____

Prior Rx: ❍ Thiotepa/Mitomycin ❍ Radiation ❍ BCG

Cysto. Findings: _____

DIAGNOSTIC TEST ORDER — Mark Location of Biopsy(s)



REQUIRED

Total # of ***BLADDER*** jars submitted: ☐

REQUIRED *for laboratory accessioning purposes*

❍ Other site(s): ❍ **TURBT/Excision/Resection**

❍ Urine Volume _____ ml
☐ Urine Cytology
☐ Cytology with **reflex** to UroVysion™ FISH if cytology is atypical/suspicious
Required: R31.9_____ or Z85.5_____
☐ UroVysion™ FISH Only
☐ Cytology with UroVysion™ FISH *(regardless of cytology results)*
Required: Z85.5_____

Collection Method Required
☐ Voided Urine
☐ Bladder Wash
☐ Catheterized Urine
☐ Post-Cystoscopy Urine
☐ Upper Tract (Right)
☐ Upper Tract (Left)
☐ Illeal Conduit/Neobladder

❍ Other:

OTHER

KIDNEY
❍ Right Mass Bx
❍ Left Mass Bx
❍ Right Mass FNA
❍ Left Mass FNA

TESTIS/EPIDIDYMIS
❍ Right Mass
❍ Left Mass
❍ Infertility
❍ Other

VAS DEFERENS
❍ Right
❍ Left

SKIN
Clinical Findings:

Site:
❍ Penis
❍ Scrotum
❍ Other

SPECIAL REQUESTS
❍ Stone Analysis:
• Site: _____
❍ PCA3

❍ Other:

In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that are medically necessary for the diagnosis and treatment of patient.

6655 N. MacArthur Blvd., Irving, Texas 75039 / 866.588.3280 / Fax 866.688.3280 / CLIA 45D0975010
15 Crawford St., Suite 100, Needham, MA 02494 / 866.588.3280 / Fax 866.688.3280 / CLIA 22D0957540

† Signature is required to order these tests.

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Specimen Labels
10000
Patient Name _____
DOB _____

Affix the appropriate label to the specimen vial you are submitting.
Include patient's first and last name and date of birth on each label.
Each label will tie back to the requisition.

Urine Cyt. UroVysion™
10000
Patient Name _____
DOB _____

Left Lateral Base 9
10000
Patient Name _____
DOB _____

Left Lateral Mid 8
10000
Patient Name _____
DOB _____

Left Lateral Apex 7
10000
Patient Name _____
DOB _____

Left Base 12
10000
Patient Name _____
DOB _____

Left Mid 11
10000
Patient Name _____
DOB _____

Left Apex 10
10000
Patient Name _____
DOB _____

Right Base 6
10000
Patient Name _____
DOB _____

Right Mid 5
10000
Patient Name _____
DOB _____

Right Apex 4
10000
Patient Name _____
DOB _____

Right Lateral Base 3
10000
Patient Name _____
DOB _____

Right Lateral Mid 2
10000
Patient Name _____
DOB _____

Right Lateral Apex 1
10000
Patient Name _____
DOB _____

Spec. _____ 16
10000
Patient Name _____
DOB _____

Left Transition Zone 15
10000
Patient Name _____
DOB _____

Right Transition Zone 13
10000
Patient Name _____
DOB _____

Spec. _____ 14
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

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INFORM™ DIAGNOSTICS

BILLING INFORMATION — PRIMARY INSURED ■ **SECONDARY** Please check box and attach copy of front and back of patient's card.

We file all primary and secondary insurance plans if information is provided. Complete fields below or attach copy of front and back of patient's card.

Payer ❍ Medicare ❍ Insurance ❍ Patient ❍ Client ❍ Other _____			Patient Status ❍ Non-hosp ❍ Hosp in-patient ❍ Hosp out-patient
Insurance Carrier	Pre-authorization Code	Policy Number/Insured ID Number	Group Number
Claims Address	Claims Phone #	Policy Holder's Name	
Policy Holder's Relationship to Patient ❍ Self ❍ Spouse ❍ Dependent		Policy Holder's DOB / /	Policy Holder's Sex ❍ M ❍ F