Inform Diagnostics Urologic Pathology Requisition

10000

INFORM DIAGNOSTICS™ A FULGENT GENETICS COMPANY

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
Date of Birth / /	Age	Sex at Birth
Street Address		Apt #
City	State	Zip
Patient Phone #	Patient Medical Record #	
Physician Signature		Order Date

BILLING INFORMATION *Attach copies of front and back of all insurance cards and PI attachment/demographic sheet*

❍ Bill Insurance
❍ Bill Client
❍ Bill Patient
❍ Bill Other _____

Patient Status
❍ Hospital Inpatient (POS 21) ❍ Hospital Off Campus (POS 19) ❍ Physician Office (POS 11)
❍ Hospital Outpatient Clinic (POS 22) ❍ Ambulatory Surgery Center (POS 24) ❍ Hospital Discharge Date ____ / ____ / ____
Facility Name: _____

ICD, CLINICAL HISTORY, & COLLECTION INFORMATION *Attach clinical note if necessary*

ICD Codes ____ / ____ / ____	Clinical History	Date of Collection ____ / ____ / ____	Time of Collection ____ AM ____ PM

PROSTATE — HISTOLOGY & PROGNOSTIC TESTS

❍ Prostate Nodule _____ ❍ Hx. of Prostate Cancer _____
❍ Elevated PSA _____
Required for Han & Partin Tables:
❍ PSA Result: _____
DRE: ❍ Normal (T1c) ❍ Abnormal, Unilateral ≤ 50% of lobe (T2a)
❍ Abnormal, Bilateral (T2c) ❍ Abnormal, Unliateral > 50% of lobe (T2b)
Prior Bx Findings: _____ ❍ Prior PCA3: _____
Prior Tx: ❍ Hormone Therapy ❍ Radiation ❍ Cryosurgery
Age at Diagnosis: _____

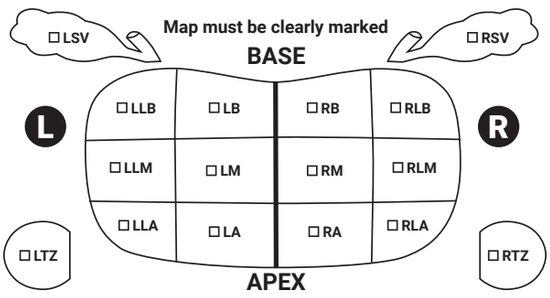
DIAGNOSTIC TEST ORDER — Mark Location of Biopsy(s)

❍ Diagnostic Prostate Biopsy ❍ TURP ❍ Saturation Biopsy
☐ PINgenius™ reflex for HGPIN
☐ ConfirmMDX™ reflex for: ☐ Negative ☐ HGPIN ☐ ASAP

PROGNOSTIC TESTS — REQUIRED

Select Gleason Grade:
❍ All Gleason grades ❍ 3+3 ❍ 3+4 ❍ 4+3 ❍ ≥8
Select Prognostic Panel:
❍ PTEN/ERG ❍ Prolaris™* ❍ Genomic Prostate Score® (GPS)* ❍ Decipher™*

Total # of Prostate Vials Submitted: ____

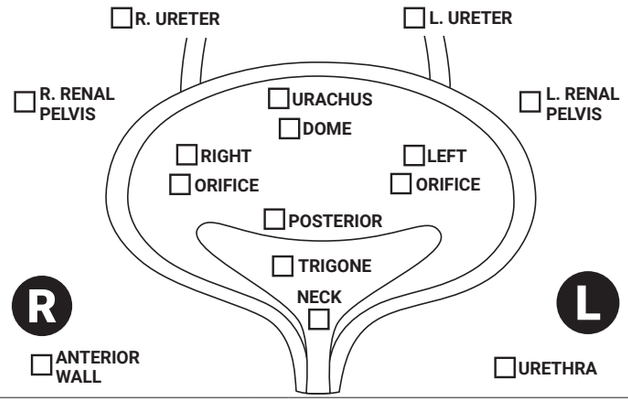


Other area of interest: _____

BLADDER, URINE CYTOLOGY, FISH

❍ Hematuria ❍ Cystitis w/ Hematuria ❍ Cystitis without Hematuria
Cysto. Findings: _____
❍ Hx. of Bladder Ca:
❑ TCC: High Grd ❑ TCC: Low Grd ❑ CIS
Prior Bx Findings: _____
Prior Rx: ❍ Thiotepa/Mitomycin ❍ Radiation ❍ BCG

DIAGNOSTIC TEST ORDER — Mark Location of Biopsy(s)



❍ Other Site(s): _____ ❍ **TURBT/Excision/Resection**

Provide Urine volume and select from testing below (1 test)
Urine Volume ____ml
☐ Urine Cytology
Urine Cytology with reflex to UroVysion™ FISH if:
☐ Negative**
☐ Atypical/Suspicious**
☐ Positive**
☐ UroVysion™ FISH**

Collection Method Required
❑ Voided Urine **
❑ Bladder Wash **
❑ Catheterized Urine
❑ Post-Cytoscopy Urine
❑ Upper Tract (RIght)
❑ Upper Tract (Left)
❑ Illeal Conduit/Neobladder

** Preferred specimen type is voided urine or bladder wash for UroVysion™ test

HISTOLOGY

Kidney Mass Biopsy
❍ Right ❍ Left
Kidney Mass FNA
❍ Right ❍ Left

Vas Deferens
(one site per vial)
❍ Right
❍ Left

Skin
Clinical Findings: _____
Site: ❍ Penis ❍ Scrotum
❍ Other _____

OTHER TESTS

❍ PCA3 Molecular Testing
❍ HPV Testing

Stone, Gross Only:
❍ Kidney Stone
❍ Bladder Stone
❍ Ureter Stone

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

1111 S. Freeport Pkwy., Coppell, Texas 75019 / 866.588.3280 / Fax 866.688.3280 / CLIA 45D0975010
15 Crawford St., Suite 100, Needham, Massachusetts 02494 / 617.969.4100

* Test is sent out. Performed and billed by another lab.

Specimen Labels 10000 Patient Name DOB	**Left Lateral Base** 9 10000 Patient Name DOB	**Left Base** 12 10000 Patient Name DOB	**Right Base** 6 10000 Patient Name DOB	**Right Lateral Base** 3 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.*	**Left Lateral Mid** 8 10000 Patient Name DOB	**Left Mid** 11 10000 Patient Name DOB	**Right Mid** 5 10000 Patient Name DOB	**Right Lateral Mid** 2 10000 Patient Name DOB
Urine Cyt. Urovysion™ 10000 Patient Name DOB	**Left Lateral Apex** 7 10000 Patient Name DOB	**Left Apex** 10 10000 Patient Name DOB	**Right Apex** 4 10000 Patient Name DOB	**Right Lateral Apex** 1 10000 Patient Name DOB
Spec. _____ 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	**Spec.** _____ 10000 Patient Name DOB