

# Inform Diagnostics Urologic Pathology Requisition

10000



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

PATIENT INFORMATION <i>Shaded fields are required</i>			
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 <i>Attach copies of front and back of all insurance cards and PI attachment/demographic sheet</i>	
<input type="radio"/> Bill Insurance <input type="radio"/> Bill Client <input type="radio"/> Bill Patient <input type="radio"/> Bill Other	<b>Patient Status</b> <input type="radio"/> Hospital Inpatient (POS 21) <input type="radio"/> Hospital Off Campus (POS 19) <input type="radio"/> Physician Office (POS 11) <input type="radio"/> Hospital Outpatient Clinic (POS 22) <input type="radio"/> Ambulatory Surgery Center (POS 24) <input type="radio"/> Hospital Discharge Date ____/____/____ Facility Name: _____

ICD, CLINICAL HISTORY, & COLLECTION INFORMATION <i>Attach clinical note if necessary</i>			
ICD Codes	Clinical History	Date of Collection	Time of Collection

PROSTATE – HISTOLOGY & PROGNOSTIC TESTS
<input type="radio"/> Prostate Nodule <input type="radio"/> Hx. of Prostate Cancer <input type="radio"/> Elevated PSA <b>Required for Han &amp; Partin Tables:</b> <input type="radio"/> PSA Result: <b>DRE:</b> <input type="radio"/> Normal (T1c) <input type="radio"/> Abnormal, Unilateral ≤ 50% of lobe (T2a) <input type="radio"/> Abnormal, Bilateral (T2c) <input type="radio"/> Abnormal, Unilateral > 50% of lobe (T2b) Prior Bx Findings: <input type="radio"/> Prior PCA3: Prior Tx: <input type="radio"/> Hormone Therapy <input type="radio"/> Radiation <input type="radio"/> Cryosurgery Age at Diagnosis:

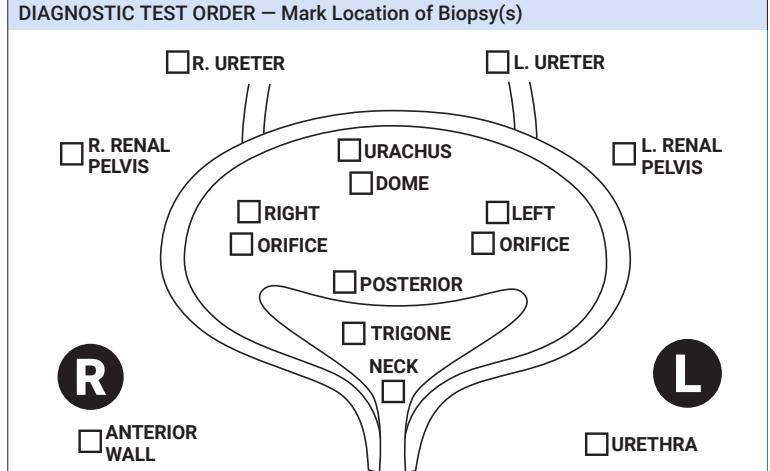
DIAGNOSTIC TEST ORDER – Mark Location of Biopsy(s)
<input type="radio"/> Diagnostic Prostate Biopsy <input type="radio"/> TURP <input type="radio"/> Saturation Biopsy <input type="checkbox"/> PINgenius™ reflex for HGPIN <input type="checkbox"/> ConfirmMDX™ reflex for: <input type="checkbox"/> Negative <input type="checkbox"/> HGPIN <input type="checkbox"/> ASAP

PROGNOSTIC TESTS	REQUIRED
Select Gleason Grade: <input type="radio"/> All Gleason grades <input type="radio"/> 3+3 <input type="radio"/> 3+4 <input type="radio"/> 4+3 <input type="radio"/> ≥8 Select Prognostic Panel: <input type="radio"/> PTEN/ERG <input type="radio"/> Prolaris™* <input type="radio"/> Genomic Prostate Score® (GPS)* <input type="radio"/> Decipher™**	Total # of Prostate Vials Submitted

Map must be clearly marked

Other area of interest: \_\_\_\_\_

BLADDER, URINE CYTOLOGY, FISH
<input type="radio"/> Hematuria <input type="radio"/> Cystitis w/ Hematuria <input type="radio"/> Cystitis without Hematuria Cysto. Findings: <input type="radio"/> Hx. of Bladder Ca: <input type="checkbox"/> TCC: High Grd <input type="checkbox"/> TCC: Low Grd <input type="checkbox"/> CIS Prior Bx Findings: Prior Rx: <input type="radio"/> Thiotepa/Mitomycin <input type="radio"/> Radiation <input type="radio"/> BCG



<input type="radio"/> Other Site(s): <input type="radio"/> TURBT/Excision/Resection	
Provide Urine volume and select from testing below (1 test) Urine Volume _ ml <input type="checkbox"/> Urine Cytology <input type="checkbox"/> Cytology with reflex to UroVysion™ FISH if atypical** <input type="checkbox"/> UroVysion™ FISH Only** <input type="checkbox"/> Cytology with UroVysion™ FISH regardless of cytology results**	<b>Collection Method Required</b> <input type="checkbox"/> Voided Urine** <input type="checkbox"/> Bladder Wash** <input type="checkbox"/> Catheterized Urine <input type="checkbox"/> Post-Cytoscopy Urine <input type="checkbox"/> Upper Tract (Right) <input type="checkbox"/> Upper Tract (Left) <input type="checkbox"/> Ileal Conduit/Neobladder

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

HISTOLOGY
<b>Kidney Mass Biopsy</b> <input type="radio"/> Right <input type="radio"/> Left <b>Kidney Mass FNA</b> <input type="radio"/> Right <input type="radio"/> Left <b>Vas Deferens</b> (one site per vial) <input type="radio"/> Right <input type="radio"/> Left <b>Skin</b> Clinical Findings: _____ Site: <input type="radio"/> Penis <input type="radio"/> Scrotum <input type="radio"/> Other _____

OTHER TESTS
<input type="radio"/> PCA3 Molecular Testing <input type="radio"/> HPV Testing <b>Stone, Gross Only:</b> <input type="radio"/> Kidney Stone <input type="radio"/> Bladder Stone <input type="radio"/> 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.

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Specimen Labels 10000 Patient Name _____ DOB _____	Left Lateral Base 10000 Patient Name _____ DOB _____	Left Base 10000 Patient Name _____ DOB _____	Right Base 10000 Patient Name _____ DOB _____	Right Lateral Base 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 10000 Patient Name _____ DOB _____	Left Mid 10000 Patient Name _____ DOB _____	Right Mid 10000 Patient Name _____ DOB _____	Right Lateral Mid 10000 Patient Name _____ DOB _____
Urine Cyt. Urovysion™ 10000 Patient Name _____ DOB _____	Left Lateral Apex 10000 Patient Name _____ DOB _____	Left Apex 10000 Patient Name _____ DOB _____	Right Apex 10000 Patient Name _____ DOB _____	Right Lateral Apex 10000 Patient Name _____ DOB _____
Spec. 10000 Patient Name _____ DOB _____	Spec. 10000 Patient Name _____ DOB _____	Left Transition Zone 10000 Patient Name _____ DOB _____	Right Transition Zone 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 _____	Spec. 10000 Patient Name _____ DOB _____