



Urologic Pathology Requisition

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Shaded fields are required.

PATIENT INFORMATION			
Last Name	First Name	MI	Accession number Place 2D barcode sticker here
Street Address		Apt. #	
City	State	ZIP	
Date of Birth	Age	Sex	
Phone #	Cell Phone #		
SSN #	Medical Record #		
Collection Date	Collection Time <input type="checkbox"/> AM <input type="checkbox"/> PM		
Please send copies of final report(s) to:			
Physician Name		Fax #	
DIAGNOSTIC INFORMATION			
<input type="checkbox"/> R97.2 Elevated PSA (790.93) <input type="checkbox"/> R31.9 Hematuria, Unspecified (599.70) <input type="checkbox"/> E66.9 Obesity, Unspecified (278.00) <input type="checkbox"/> C61 Prostate Cancer (185) <input type="checkbox"/> R31.0 Gross Hematuria (599.71) <input type="checkbox"/> R35.0 Frequency of Micturition (788.41) <input type="checkbox"/> D40.0 Neoplasm of Uncertain Behavior of Prostate (236.5) <input type="checkbox"/> R31.1 Microscopic Hematuria (599.72) <input type="checkbox"/> D07.5 Carcinoma In Situ of Prostate (233.4) <input type="checkbox"/> N40.1 Enlarged Prostate With LUTS (600.01, 600.21, 600.91) <input type="checkbox"/> C67.9 Malignant Neoplasm of Bladder (188.9) <input type="checkbox"/> G93.3 Postviral Fatigue Syndrome (780.79) <input type="checkbox"/> N40.2 Nodular Prostate Without LUTS (600.10) <input type="checkbox"/> High Grade <input type="checkbox"/> Low Grade <input type="checkbox"/> Z85.46 Personal History of Prostate Cancer (V10.46) <input type="checkbox"/> D09.0 Carcinoma In Situ of Bladder (233.7) Other _____ <input type="checkbox"/> Z80.42 Family History of Prostate Cancer (V16.42) <input type="checkbox"/> Z85.51 Personal History of Bladder Cancer (V10.51) <input type="checkbox"/> Z80.52 Family History of Bladder Cancer (V16.52)			
CLINICAL INFORMATION		PREVIOUS BIOPSY	PREVIOUS THERAPY
PSA last result* _____ Date _____ *required for Partin Table	<input type="checkbox"/> Benign <input type="checkbox"/> HGPIN <input type="checkbox"/> Atypical/Suspicious <input type="checkbox"/> Adenocarcinoma Gleason Score _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Prostatectomy <input type="checkbox"/> BCG <input type="checkbox"/> Radiation <input type="checkbox"/> Mitomycin <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Thiotepa <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Active Surveillance/Watchful Waiting <input type="checkbox"/> Other _____	
DRE/Clinical Stage (if malignant diagnosis): <input type="checkbox"/> Normal (T1c) <input type="checkbox"/> Abnormal, Unilateral ≤ 50% of lobe (T2a) <input type="checkbox"/> Abnormal, Unilateral > 50% of lobe (T2b) <input type="checkbox"/> Abnormal, Bilateral (T2c)			
BILLING INFORMATION			
Bill To: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Client <input type="checkbox"/> Patient/Self-Pay			
Service Type: <input type="checkbox"/> Global <input type="checkbox"/> TC ONLY <input type="checkbox"/> TC with Global Bill <input type="checkbox"/> PC ONLY <input type="checkbox"/> PC with Global Bill			
Primary Insurance: (or attach card copy)		Policy #	Group #
Plan name		Phone #	
Plan address			
Name of subscriber		Patient relationship to subscriber	
Secondary Insurance: (or attach card copy)		Policy #	Group #
Plan name		Phone #	
HISTOLOGY	PROSTATE REFLEX	CYTOLOGY/FISH	
Specimen Type <input type="checkbox"/> Prostate Biopsy <input type="checkbox"/> Multiple <input type="checkbox"/> Saturation # of cores _____ <input type="checkbox"/> TURP <input type="checkbox"/> Bladder Biopsy <input type="checkbox"/> TURBT <input type="checkbox"/> Vas Deferens <input type="checkbox"/> Other _____	ProMark & PTEN/ERG reflex: <input type="checkbox"/> If Gleason 3+3 or 3+4: ProMark ; If not enough tissue for ProMark, PTEN/ERG If Gleason 4+3/HGPIN/Atypical/Suspicious/ASAP: PTEN/ERG <input type="checkbox"/> ProMark only (Gleason 3+3 or 3+4) <input type="checkbox"/> PTEN <input type="checkbox"/> PTEN/ERG Recommended: <input type="checkbox"/> Gleason Score 6 or 7/HGPIN/Atypical/Suspicious/ASAP Individual Reflex (please select all that apply): <input type="checkbox"/> Gleason Score 6 or 7 <input type="checkbox"/> HGPIN <input type="checkbox"/> Atypical/Suspicious <input type="checkbox"/> ASAP <input type="checkbox"/> Other _____	Procedure <input type="checkbox"/> Cytology and FISH Molecular Assay <input type="checkbox"/> Cytology Reflex FISH if Cytology is Atypical/Suspicious <input type="checkbox"/> Cytology Reflex FISH if Cytology is: _____ <input type="checkbox"/> FISH Molecular Assay Only <input type="checkbox"/> Cytology Only <input type="checkbox"/> Other: _____ Specimen Type <input type="checkbox"/> Voided urine <input type="checkbox"/> Renal washings <input type="checkbox"/> Catheterized urine <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bladder washings <input type="checkbox"/> Ureteral washings <input type="checkbox"/> Post-cystoscopy void <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Other: _____ <input type="checkbox"/> Neobladder/ileal conduit	

I authorize testing and confirm: 1) that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient; 2) that informed consent has been obtained; and 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to Metamark Genetics, Inc. (Metamark). I authorize Metamark to contact the patient, if necessary, for testing authorization and discussion of financial responsibility. I authorize Metamark to release the information on this form and other information provided by me that is necessary to process a claim for this service.