

PART A: Patient Information (Required)

Last Name: _____ First Name _____
 Date of Birth: ____/____/____ Gender: M F
 Address: _____
 City _____ State _____ Zip Code _____

Accession # _____

PART B: Provider Information - Required

Provider: _____
 Address: _____
 City _____ State _____ Zip Code _____
 Phone: _____ Fax: _____
 NPI# _____ Signature _____

PART C: Clinical History/Indications : PSA (ng/mL)

- | | |
|--|--|
| <input type="checkbox"/> Gross hematuria (R31.0) | <input type="checkbox"/> Bladder cancer (C67.9) |
| <input type="checkbox"/> Benign Hematuria (R31.1) | <input type="checkbox"/> Neoplasm of bladder (D49.4) |
| <input type="checkbox"/> Abnormal findings cyto/histo (R82.89) | <input type="checkbox"/> Acute cystitis (N30.0) |
| <input type="checkbox"/> Abnormal findings urine (R82.90) | <input type="checkbox"/> Cystitis, unspecified (N30.9) |

PSA Density _____

- Prostate cancer (C61)
- Disorder of prostate (N42.9)
- Elevated PSA (R97.20)
- Prostatocystitis (N41.3)
- Acute prostatitis (N41.0)

Clinical Stage _____

- Prostatitis, other (N41.8)
- Genital disorder, Male (N50.9)
- Genital neoplasm (C63.9)
- Sterilization (Z30.2)
- _____

PART D: Insurance Billing Information:

Send Bill to: Patient Insurance

Name of Primary Insurance CO _____ Insured ID _____ Group # _____
 Relationship to Insured Self Spouse Child Other
 Insured's Name _____ Insured Date of Birth ____/____/____

Please Attach: 1) A copy of the front/back of patient's insurance card(s) and/or 2) Printout patient demographics and insurance information from your EHR

PART E: Specimen Information:

Specimen Collection Date: ____/____/____ # of Container(s): _____

I. Prostate Biopsy (Specimen Site): **Other Biopsy (Specimen Site):** A: _____ B: _____

- | | |
|-------------------------|------------------------|
| A: Right base _____ | B: Right mid _____ |
| C: Right apex _____ | D: Left base _____ |
| E: Left mid _____ | F: Left apex _____ |
| G: Right lat base _____ | H: Right lat mid _____ |
| I: Right lat apex _____ | J: Left lat base _____ |
| K: Left lat mid _____ | L: Left lat Apex _____ |
| M: _____ | N: _____ |

II. Bladder Biopsy (Specimen Site):

- | | |
|----------|----------|
| A: _____ | B: _____ |
| C: _____ | D: _____ |

III. Urine Cytology: _____ **Urine FISH:** _____

(Indicate if voided _____ or instrument _____)

Urine Other Tests: Feulgen _____ IHC (CK17) _____

UTI Panel + ABx Res UTI Panel ABx Res

UTI Panel: E. coli, K. pneumoniae, S. agalactiae (GBS), P. aeruginosa, S. saprophyticus, E. faecium, S. aureus, Pan-Candida [C. glabrata, C. parapsilosis, C. tropicalis, C. albicans]

ABx Res: blaKPC, blaCTX-M, blaNDM, VanA, VanB, DfrA17, Sul1, MecA, AadA1, AAC(3)-Ia, AAC(6)-Ib-cr, AAC(6)-Ib

FOR LAB USE ONLY:

Receiving Date: _____ Time: _____ Accession# _____ Note: _____