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Urologic Pathology Requisition

CHART #:	SOCIAL SECURITY #:	COLLECTION DATE:
PATIENT'S NAME (LAST, FIRST, MI):	COLLECTION TIME:	
HOME ADDRESS, CITY, STATE, ZIP		
PATIENT PHONE #:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:
SUBMITTING PHYSICIAN:		

**For insurance billing - please fill out form in entirety or COPY insurance card
FAILURE TO FILL OUT FORM COMPLETELY WILL CAUSE DELAY OF TEST RESULT**

PRIMARY INSURANCE:	ID#:	GROUP #:	
INSURANCE ADDRESS:			
INSURANCE PHONE #:	INSURANCE SUBSCRIBER:	DOB	RELATIONSHIP TO PATIENT:
SECONDARY INSURANCE:	ID#:	GROUP #:	
INSURANCE ADDRESS:			
INSURANCE PHONE #:	INSURANCE SUBSCRIBER:	DOB	RELATIONSHIP TO PATIENT:
ICD-9/DIAGNOSIS(ES):			

PROSTATE PATHOLOGY

A. CLINICAL HISTORY

PSA _____ ng/ml % Free PSA _____
 Digital Rectal Exam Suspicious Non-Suspicious
 Hypochoic Lesion Suspicious Non-Suspicious
 Previous Biopsy? None Negative Suspicious Positive
 Other: _____

B. THERAPY

TURP Prostatectomy Hormone Therapy
 Cryosurgery Chemotherapy Radiation Therapy

C. # OF JARS _____ # OF CORES SUBMITTED _____

D. TEST REQUEST

Prostate Histology (Including separately billable stains determined by the pathologist)
 Prostate Histology (Contact my office prior to adding separately billable stains)

E. MAPPING REPORT (For cases with more than 2 jars)

____ Lt. Lat. Base ____ Lt. Base ____ Rt. Base ____ Rt. Lat. Base
 ____ Lt. Lat. Mid ____ Lt. Mid ____ Rt. Mid ____ Rt. Lat. Mid
 ____ Lt. Lat. Apex ____ Lt. Apex ____ Rt. Apex ____ Rt. Lat. Apex
 ____ Lt. Sv ____ Rt. Sv ____ Lt. Tran Zone ____ Rt. Tran Zone
 Other: _____

ADDITIONAL UROLOGY SERVICES

A. NUMBER OF JARS _____

B. JARS LABELED

A. _____ C. _____
 B. _____ D. _____

C. CLINICAL HISTORY _____

URINE CYTOLOGY

A. CLINICAL HISTORY

TCC Currently or History: Dx Date _____
 Hematuria Proteinuria Dysuria Cystitis Diabetes
 Other: _____

B. THERAPY

TURB BCG Mitomycin Thiotepa

C. SPECIMEN COLLECTION TYPE

Voided Urine
 Cath Urine Bladder Wash Ileal Conduit
 Other: _____

STONE ANALYSIS REQUESTED

A. Stone Composition

We will perform the test that provides the definitive result, either infrared Spectroscopy or X-Ray Diffraction)

B. Physician Signature (required) _____

C. Specimen Obtained:

Spontaneously passed Lithotripsy Surgically removed

D. Stone Location _____

FOR LABORATORY USE ONLY

TIME RECEIVED	# SPEC	# BLOCKS	# SLIDES	PREP TECH	PATHOLOGIST
ACCESSION #	FILTERS	GROSS DESCRIPTION		RECEIVED _____ ml OF <input type="checkbox"/> CLEAR <input type="checkbox"/> BLOODY FLUID	