Urological Pathology Requisition

Sterling Pathology
National Laboratories
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CLIA 05D1012129

U35178

Phone: 1-562-799-8900
Fax: 1-562-799-8901
Toll Free: 1-800-899-8480

PHYSICIAN INFORMATION

AUTHORIZED SIGNATURE _____

Copy of report to: Dr. _____ Address _____ Fax # _____

PATIENT INFORMATION
Please write or affix label

Name (Last, First, Middle) _____ Sex - DOB _____ SSN/MR # _____

Address: _____ Phone: _____

BILLING INFORMATION
Please attach face sheet or copy of insurance

Bill: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient ☐ Client Bill

Primary Insurance Carrier _____ Policy# / ID# _____

Secondary Insurance Carrier _____ Policy# / ID# _____

PROSTATE/ BLADDER/ OTHER HISTOLOGY INFORMATION

ICD-10 / Diagnosis: _____ No. of Samples: _____

Collection Date: _____ Collection Time: _____ ☐AM ☐PM ☐Saturation Biopsy Performed

PSA: _____ ng/ml Date: _____ **DRE:** ☐Normal ☐Abnormal _____ ☐Ultrasound _____

HISTOLOGY

DISEASE STAGE/CLINICAL COURSE

DRE/Clinical Stage:
- ☐Normal/T1c
- ☐Isolated Nodule//T2b
- ☐Suspicious/T2a
- ☐Multiple Nodules/T2c

Previous Biopsy:
- ☐Adenocarcinoma
- ☐Suspicious/ASAP
- ☐Benign
- ☐HGPIN

Previous Therapy:
- ☐Radiation Therapy
- ☐Hormonal
- ☐Chemotherapy
- ☐Cryotherapy
- ☐Surgery
- ☐Other _____

TEST REQUEST:
- ☐Prostate Histology
- ☐Prostate Histology w/DNA Ploidy*
- ☐Bladder Histology
- ☐Vas Deferens Histology
- ☐Histology Other: _____

☐ConfirmMDx for Prostate Cancer
For all negative and HGPIN prostate biopsies

**DNA Ploidy performed when requested only on malignant cells Pathologists may order additional stains when needed at an additional charge.*

CYTOLOGY

ICD-10 / Diagnosis: _____ Collection Date: _____ Collection Time: _____ ☐AM ☐PM

Specimen Type
- ☐First Morning Void
- ☐Bladder Wash
- ☐Post Cysto Void
- ☐Random Void
- ☐Other: _____
- ☐Catheterized Urine
- ☐Ileal Conduit/Neobladder
- ☐Renal Wash ☐Right ☐Left

Previous Therapy
- ☐BCG
- ☐TURB
- ☐Other: _____
- ☐Radiation
- ☐Chemotherapy

Cystoscopy
☐Normal ☐Abnormal

Clinial History
- ☐Bladder CA
- ☐Renal Transplant
- ☐Other _____
- ☐Hematuria
- ☐Diabetes

TEST REQUEST:
- ☐Cytology
- ☐Cytology reflex FISH*
- ☐Cytology/FISH
- ☐FISH
- ☐Other: _____

**Reflex when results are atypical. Pathologist may order stains or additional tests when required at an additional charge.*

OTHER

ICD-10 Code/Diagnosis _____ Completion Date _____ Time _____

☐PCA3 Test Request _____

SUPPLY REQUEST

For additional supplies please contact client services at 1-800-899-8480 UR2013V1

1.Complete the requisition with all requested information. **2**.Remove the required number of labels from the front of this sheet. **3**.Place one (1) label on each specimen container (not on the lid). **4**.Please dispose unused labels. **Note: Please label each specimen with patient's name and site.**

U35178 Left Lateral Base Name _____	U35178 Left Base Name _____	U35178 Right Base Name _____	U35178 Right Lateral Base Name _____
U35178 Left Lateral Mid Name _____	U35178 Left Mid Name _____	U35178 Right Mid Name _____	U35178 Right Lateral Mid Name _____
U35178 Left Lateral Apex Name _____	U35178 Left Apex Name _____	U35178 Right Apex Name _____	U35178 Right Lateral Apex Name _____
U35178 Left Seminal Vesicle Name _____	U35178 Left Name _____	U35178 Right Name _____	U35178 Right Seminal Vesicle Name _____
U35178 Cytology/FISH Name _____	U35178 PCA3 Name _____	U35178 Name _____	U35178 Name _____