Pathology Solutions, LLC
246 Industrial Way West, Eatontown, NJ 07724
Phone: 732-389-5200 Fax: 732-389-5299

UR9_01001

☐ RUSH
Call results to: ____________

UROLOGY 9 REQUISITION

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address	Apt. #	
City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth / /	Age	Sex	Patient ID

CLIENT INFORMATION

Treating Physician | UPIN #

Required for NY, NJ, MA and PA

Physician's Signature X ____________

Send Duplicate of Report to:
Name ____________
Address/Fax ____________

BILLING / INSURANCE (attach copy of insurance card - both sides)

Bill:
- ☐ Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Worker's Comp
- ☐ Patient
- ☐ Physician
- ☐ Hospital
- ☐ Other
- ☐ Outpatient/Non-hospital
- ☐ Hospital (IP/OP/ER)

Subscriber Insurance ☐ Secondary Insurance Information Attached
Subscriber Name / Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent
Company Name
Address

City	State	Zip
Employer Name		
Subscriber DOB: / /	Group/Contract #	Member ID#
Subscriber Sex: ☐ Male ☐ Female	Medicare #	Medicaid ID#

ICD-9 CODE(S) (Required) ____________

For any patient of any payor (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient. Provide signed ABN when necessary.

PROSTATE

CLINICAL INFORMATION
- ☐ Diagnostic Prostate Biopsy (indicated for initial dx)
- ☐ Saturation Biopsy (indicated for tumor staging of an established dx)

Required for Partin Table
PSA ________ ng/ml
Date ________
DRE
☐ Normal
Abnormal (Check Box Below)
- ☐ Unilateral < 1/2 lobe
- ☐ Unilateral > 1/2 lobe
- ☐ Bilateral

☐ Prostate History:

☐ PROSTATE BIOPSY MAP
Left Seminal Vesicle | Right Seminal Vesicle
BASE
Left Lateral Base | Left Base | Medial Base | Right Base | Right Lateral Base
Left Lateral Mid | Left Mid | Medial Mid | Right Mid | Right Lateral Mid
Left Lateral Apex | Left Apex | Medial Apex | Right Apex | Right Lateral Apex
APEX
Left Transition Zone | Right Transition Zone
L R
Other Locations ________
Please mark location of biopsy.

Previous biopsy: Date ____/____/____
☐ None ☐ Benign ☐ Inflammation ☐ Atypia ☐ HPIN ☐ Malignant ☐ Other________

Previous therapy:
Date ____/____/____ ☐ None ☐ Hormonal ☐ Radiation ☐ Chemotherapy
☐ Cryosurgery ☐ Surgery ☐ Other ____________

URINARY BLADDER

CLINICAL INFORMATION
☐ Bladder History: ____________
Cystoscopy: Date ____________
☐ Normal ☐ Abnormal
Abnormal findings: ____________

Previous cytology exam: ☐ None
Date ____/____/____ ☐ Negative
☐ Low Grade ☐ High Grade
☐ Other ____________

Previous therapy:
Date ____/____/____ ☐ None ☐ BCG
☐ Radiation ☐ Chemotherapy ☐ Surgery
☐ Other ____________

☐ BLADDER BIOPSY
R L
Dome
Right | Posterior | Left
Rt. Trigone | Lt. Trigone
Urethra
ANTERIOR
Please mark location of biopsy. Other Locations ________

URINE
- ☐ Urine Cytology ☐ Urine FISH
- ☐ FISH *Plus* (Urine Cytology and Urine FISH with correlative interpretation)
- ☐ Reflex Urine FISH if abnormal Urine Cytology
- ☐ Other ____________

Reflex test performed at an additional charge.

Specimen Type/Volume: ________ **ml**

☐ VU (voided urine)	☐ BW (bladder wash)	☐ Renal wash R____ L____
☐ PCV (post cysto voided urine)	☐ Neo bladder	☐ Urethral wash
☐ CU (catheterized urine)	☐ Other________	☐ Ureteral wash R____ L____

OTHER PATHOLOGY
- ☐ Vas deferens ☐ R ☐ L ☐ Both ☐ Kidney ☐ Second Opinion ________
- ☐ Penis ☐ Testis ☐ External Genitalia ☐ Other Sites ________

KIDNEY STONE DISEASE MANAGEMENT
☐ Stone-A-Lyzer® (stone composition analysis)

24-Hour Urine Profiles
- ☐ UroRisk Diagnostic Profile ☐ StoneRisk Citrate ☐ StoneRisk Cystine
- ☐ StoneRisk Diagnostic Profile ☐ StoneTrack Diagnostic Monitoring Test

24-Hour Urine Custom Profile **Volume Collected:** ________ ml

☐ Calcium	☐ Creatinine	☐ Oxalate	☐ Potassium
☐ Chloride	☐ Cystine	☐ pH	☐ Sodium
☐ Citrate	☐ Magnesium	☐ Phosphorus	☐ Uric Acid
☐ Other ________			

ADDITIONAL TESTS

These offerings may require special studies, markers or stains as deemed appropriate for proper evaluation by Pathology Solutions, LLC pathologist. These additional tests may result in additional charges.

Date & Time Specimen Collected ________ **By** ________ **Date & Time Specimen Collected** ________ **By** ________

LAB USE ONLY

MARGINAL WORDS UROLOGY 9

UR9_01001 Left Lateral Base	UR9_01001 Medial Base	UR9_01001 Right Lateral Base	UR9_01001 Specimen Box
UR9_01001 Left Lateral Mid	UR9_01001 Medial Mid	UR9_01001 Right Lateral Mid	UR9_01001 Bladder
UR9_01001 Left Lateral Apex	UR9_01001 Medial Apex	UR9_01001 Right Lateral Apex	UR9_01001 Cytology
UR9_01001 Left Base	UR9_01001 Left Sem Ves	UR9_01001 Right Base	UR9_01001 Right Sem Ves
UR9_01001 Left Mid	UR9_01001 Left Trans Zone	UR9_01001 Right Mid	UR9_01001 Right Trans Zone
UR9_01001 Left Apex	UR9_01001 Left	UR9_01001 Right Apex	UR9_01001 Right

AURORA DIAGNOSTICS PROOF