UP

REFERRED BY

PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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DALLAS, TX 75247
P 214.638.2000
P 800.258.1253
F 214.237.1731
www.ProPath.com

PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS | APT#

CITY | STATE | ZIP

(AREA CODE) PHONE | BIRTH DATE | SEX

PATIENT S.S. # | PATIENT I.D.#

Complete Shaded Box For Patient And Third Party Billing

BILL TO: ☐ **Account** ☐ **Patient (Self Pay)** ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ***Please submit a copy of ID card (front and back)**

INSURANCE COMPANY NAME (attach card) | EMPLOYER NAME

NAME OF INSURED | POLICY / MEMBER ID # | GROUP #

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician: _____ NPI: _____

DATE COLLECTED

Send Duplicate Report to: _____
Name: _____
Address: _____
City/State/Zip: _____

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE | DIAGNOSIS CODE | DIAGNOSIS CODE

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. ***Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.***

Physician's Signature: _____ **Date Ordered:** _____

UROLOGICAL PATHOLOGY REQUISITION

CLINICAL INFORMATION

_____PSA Date _____/_____/_____ **DRE:** ☐ Normal ☐ Abnormal **Cystoscopy:** ☐ Normal ☐ Abnormal **Urinary FISH Panel:** ☐ Normal ☐ Abnormal

Previous Biopsy: Date _____/_____/_____ ☐ None ☐ Benign ☐ Inflammation ☐ Atypia ☐ HPIN ☐ Malignant ☐ Other _____

Previous Cytology Exam: Date _____/_____/_____ ☐ None ☐ Benign ☐ Atypia ☐ Dysplasia ☐ Malignant ☐ Other _____

Previous Therapy: ☐ None ☐ Hormonal ☐ BCG ☐ Radiation ☐ Chemotherapy ☐ Cryosurgery ☐ Surgery ☐ Other _____

- ☐ Elevated PSA (R97.20)
- ☐ Rising PSA following treatment for malignant neoplasm of prostate (R97.21)
- ☐ Encounter for screening for malignant neoplasm of prostate (Z12.5)
- ☐ Neoplasm of uncertain behavior of prostate (D40.0)
- ☐ Other specified disorders of prostate (N42.89)
- ☐ Prostate Cancer (C61)
- ☐ Prostate Nodule w/o lower urinary tract symptoms (N40.2)
- ☐ Prostate Nodule with lower urinary tract symptoms (N40.3)
- ☐ History of Bladder Cancer (Z85.51)
- ☐ Benign Bladder Neoplasm (D30.3)
- ☐ Acute Cystitis w/o hematuria (N30.00)
- ☐ Acute Cystitis with hematuria (N30.01)
- ☐ Other Chronic Cystitis w/o hematuria (N30.20)
- ☐ Other Chronic Cystitis with hematuria (N30.21)
- ☐ Interstitial Cystitis w/o hematuria (N30.10)
- ☐ Interstitial Cystitis with hematuria (N30.11)
- ☐ Renal Cancer (kidney except pelvis) (C64.**) **Required 4th digit based on locality
- ☐ Renal Cancer (renal pelvis) (C65.**) **Required 4th digit based on locality
- ☐ Hematuria, unspecified (R31.9)
- ☐ Other (ICD-10) _____
- ☐ Additional Findings: _____

CYTOLOGY

- ☐ Urine Cytology
- ☐ Urine Cytology (with REFLEX urinary FISH panel for atypical/ suspicious results)
- ☐ Urinary FISH panel
- ☐ Other: _____

Specimen Type / Volume: _____ ml

- ☐ VU (voided urine) ☐ CU (catheterized urine)
- ☐ BW (bladder wash) ☐ PCV (post cysto voided urine)
- ☐ Renal Wash L _____ R _____
- ☐ Ureteral Wash L _____ R _____
- ☐ Neo Bladder
- ☐ Other: _____
- ☐ Additional Info: _____

HISTOLOGY

Test(s) required. Please check box

- ☐ Prostate
- ☐ Bladder
- ☐ Vas Deferens
- ☐ Stone
- ☐ Seminal Vesicle
- ☐ Ureter
- ☐ Testis
- ☐ Kidney
- ☐ Penis
- ☐ Urethra
- ☐ Other: _____

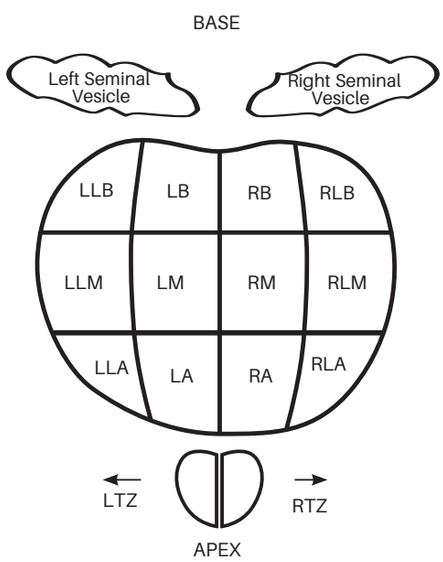
CLINICAL HISTORY/IMPRESSION/OTHER INFORMATION

_____
_____
_____
_____
_____
_____
_____

DESCRIPTION

SITE		SITE	
Left Base LB	Name _____	Right Base RB	Name _____
Left Mid LM	Name _____	Right Mid RM	Name _____
Left Apex LA	Name _____	Right Apex RA	Name _____
Left Lat Base LLB	Name _____	Right Lat Base RLB	Name _____
Left Lat Mid LLM	Name _____	Right Lat Mid RLM	Name _____
Left Lat Apex LLA	Name _____	Right Lat Apex RLA	Name _____
LT Transitional LTZ	Name _____	LT Transitional RTZ	Name _____
LT _____ (location)	Name _____	RT _____ (location)	Name _____
_____ (source)	Name _____	_____ (source)	Name _____

PROSTATE BIOPSY SPECIMEN SITES



v12/22

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.