

PATHOLOGY REFERENCE LABORATORY, L.L.C.



UROLOGY REQUISITION

9600 DATAPOINT DR. • SAN ANTONIO, TX 78229
 TELE (210) 892-3700 • TOLL FREE (866) 231-8058 • FAX (210) 617-4692

COLLECTION DATE: ____/____/____

- BILL TO:
- CLIENT
 - PATIENT
 - OTHER

ACCOUNT NAME AND ADDRESS

PATIENT LAST NAME		FIRST		M.I.	
RELATIONSHIP TO INSURED: <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT					
PHONE ()	PATIENT SS #	PATIENT ID/MR #	DATE OF BIRTH / /	SEX <input type="radio"/> F <input type="radio"/> M	
INSURED NAME/RESPONSIBLE PARTY			INSURED SS #		
PATIENT ADDRESS (OR INSURED RESPONSIBLE PARTY)					APT. NO.
CITY			STATE	ZIP	
EMPLOYEE NAME			PHONE ()		
INSURANCE COMPANY NAME					
INSURANCE COMPANY ADDRESS					
CITY			STATE	ZIP	
INSURANCE COMPANY PHONE ()		INSURANCE/GROUP #		MEMBER/SUBSCRIBER ID #	
MEDICARE #	SUFFIX <input type="radio"/> PRIMARY <input type="radio"/> SECONDARY	MEDICAID #		STATE	

Send duplicate report to:

Name _____ Address/Fax _____

ICD-9 CODE (Required)

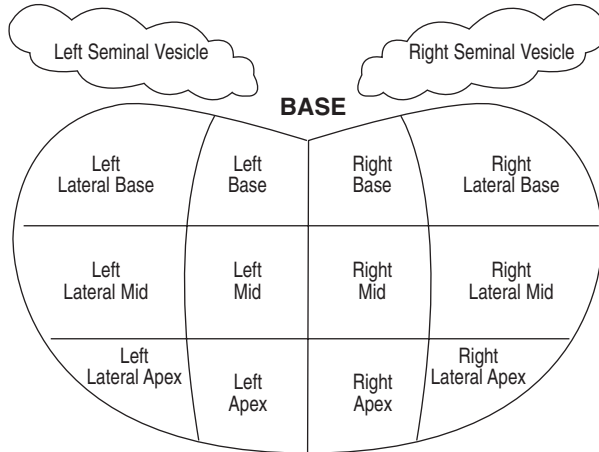
Medicare patients must review and sign the separate Advanced Beneficiary Notice for noncovered services

HISTOLOGY

Test(s) required. Please check box.

Tissue type: _____

- Prostate Histology only
- Bladder Histology
- Ureter
- Vas Deferens
 - #1 R or L #2 R or L
- Skin _____
- Other _____



L

R

CYTOLOGY

Test(s) required. Please check box.

- Urine Cytology
 - _____
 - _____
 - _____
- 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
 - Barbotage
 - Other _____

PSA _____ NG/uL Date _____

DRE: Normal Abnormal

Abnormal findings: _____

Previous Biopsy: None Benign Inflammation

Atypia HPIN Malignant

Other _____

Previous Therapy: None Hormonal BCG

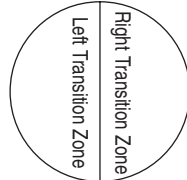
Radiation Chemotherapy Cryosurgery

Surgery Other _____

Date & Time Specimen Collected

By

APEX



Please designate specimen sites by number:

Other Sites: _____

Cystoscopy: Normal Abnormal

Abnormal findings: _____

Previous Cytology Exam: Date _____

None Benign Atypia Malignant Dysplasia

Other _____

Previous Therapy:

None BCG Radiation Chemotherapy

Surgery Other _____

Date & Time Specimen Collected

By

LAB USE ONLY