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UROLOGIC PATHOLOGY REQUISITION

Laboratory use only

Date:

PATIENT INFORMATION:

Social Security No

Last Name | First Name | Middle Name

Address | Physician Name

City | State | ZipCode | Medicare/Medicaid Authorized Physician /Practitioner signature (REQUIRED)

Age | Sex | Date of Birth | Physician Address

SOURCE OF TISSUE:

PERTINENT CLINICAL INFORMATION:

FOR PROSTATE BIOPSIES:

PSA level

Is there a palpable lesion on DRE or an identifiable lesion on ultrasound? ____ Yes ____ No

If yes, state location:

BILLING INFORMATION:

Medicaid # | Medicare #

OTHER INSURANCE:

Name | Policy #

Address | Group #

Policy Holder's Name | Employer

IF THIS FORM IS NOT FULLY COMPLETED, THE PROCESSING OF THIS SPECIMEN WILL BE DELAYED
SPECIMEN TO BE PLACED IN 10% FORMALIN AS SOON AS OBTAINED