avero DIAGNOSTICS
Pathology, Molecular Diagnostics, Research

Client Services: 1-877-232-9924

UROLOGIC PATHOLOGY REQUISITION

123456789

Specimen Collection Date:_____Time: _____

PATIENT INFORMATION

Patient Name (Last, First, MI) | Chart#

SSN | DOB | Sex M / F

Address

City | State | ZIP

PHYSICIAN INFORMATION

Patient Insurance Information - Please provide copy of insurance card(s)

Primary Insurance ☐Medicare ☐Ins. ☐Patient ☐Client Bill

Company

Policy / ID Number

Group Number

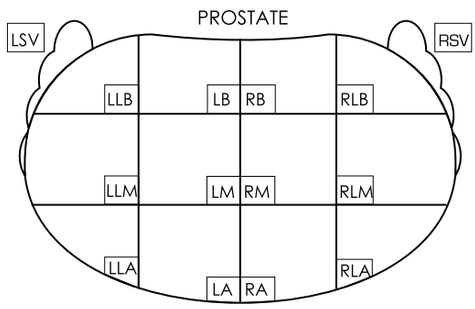
Secondary Insurance ☐Medicare ☐Ins.

Company

Policy / ID Number

Group Number

CLINICAL DIAGRAM (Mark Location of Biopsy(s))



DIAGNOSTIC INFORMATION (ICD-9) Check all that apply

☐	188.9 Malig. Neo. of Bldr.	☐	788.33 Mixed Incontinence
☐	596.51 Frequency Urgency	☐	790.93 Elevated PSA
☐	599.71 Hematuria (Gross)	☐	V10.51 Hx. of Bladder Ca.
☐	599.72 Hematuria (Micro)	☐	V10.46 Hx. of Pca
☐	600.01 Nodular Prostate	☐	V25.2 Sterilization/Vas.
☐	788.1 Dysuria		

CLINICAL & THERAPY HISTORY

PROSTATE

☐ Last PSA Result _____ Date _____
☐ D.R.E: Negative ☐ D.R.E. Suspicous
☐ Hypoechoic Lesion: Suspicious
☐ Hormone Therapy
☐ Prior Biopsy: Date:_____
Result: ☐Benign ☐Atyp/Susp. ☐HGPIN ☐Pca

☐ TURP
☐ Cryosurgery
☐ Radiation
☐ HIFU

BLADDER

☐ TCC History: Dx Date: _____ Grade:_____
☐ Hematuria
☐ Dysuria
☐ Proteinuria
☐ Cystitis

☐ TURB
☐ BCG
☐ Mitomycin
☐ Thiotepa

OTHER

TEST ORDERED

PROSTATE PATHOLOGY ☐ TECHNICAL PREPARATION ONLY

☐ Prostate Histology
☐ Prostate Histology w/Reflex PCA3 if biopsy non-positive
☐ PCA3 Only

OTHER PATHOLOGY ☐ TECHNICAL PREPARATION ONLY

☐ Bladder Histology
☐ Testicular Histology-Infertility
☐ Testicular Histology-Other
☐ Vas Deferens
☐ Penile Histology
☐ Skin (Specify Site) _____
☐ Other_____

CYTOLOGY

☐ Urine Cytology
☐ Technical Only Urine Cytology

FISH

☐ UroVysion FISH
☐ UroVysion FISH if Cyto. Atyp or Suspicious
☐ Tech Only UroVysion FISH
☐ Tech Only UroVysion FISH if Cyto. Atyp or Suspicious

Specimen Collection:

☐ Voided Urine
☐ Catheterized Urine
☐ Illeal Conduit/Neobladder
☐ Upper Tract_____
☐ Bladder Wash
☐ Post Cystoscopy Voided Urine

ALL MEDICARE PATIENTS MUST COMPLETE THE FOLLOWING: Medicare will only pay for services determined to be "reasonable and necessary" under section 1662(a) of the Medicare law. If Medicare determines that a particular service is not reasonable and or necessary under Medicare program standards, Medicare will deny payment for that service.

Patient Signature:_____ Date:_____

1. Complete the requisition with all requested information. 2. Clearly print the patient name on the label (do not write on the bar code) 3. Place one label on each specimen container(not the lid) 4. Please discard unused vials.

123456789 Left Lateral Apex Patient Name	123456789 Left Apex Patient Name	123456789 Right Apex Patient Name	123456789 Right Lateral Apex Patient Name	123456789 Urine Cytology Patient Name
123456789 Left Lateral Mid Patient Name	123456789 Left Mid Patient Name	123456789 Right Mid Patient Name	123456789 Right Lateral Mid Patient Name	123456789 UroVysion FISH Patient Name
123456789 Left Lateral Base Patient Name	123456789 Left Base Patient Name	123456789 Right Base Patient Name	123456789 Right Lateral Base Patient Name	123456789 Bladder Patient Name
123456789 Left Seminal Ves. Patient Name	123456789 Left Prostate Patient Name	123456789 Right Prostate Patient Name	123456789 Right Seminal Ves. Patient Name	123456789 Testicle Patient Name
123456789 Left Trans Zone Patient Name	123456789 _____ Patient Name	123456789 _____ Patient Name	123456789 Right Trans Zone Patient Name	123456789 Vas Deferens 1 Patient Name
123456789 PCA3 Spec. 1 Patient Name	123456789 PCA3 Spec. 2 Patient Name	123456789 PCA3 Spec. 3 Patient Name	123456789 PCA3 Spec. 4 Patient Name	123456789 Vas Deferens 2 Patient Name

AVERO COPY