# UROLOGY TEST REQUISITION

South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

Client Name: _____
✓ Physician's Last Name, First Name
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

**Signature of Ordering Provider**

_____
**(Signature must be dated, legible, and include first and last name)**

**Date**_____

**PATIENT INFORMATION – Please PRINT**

Name _____
Last First MI

SS# _____

DOB _____ SEX _____
MO / DAY / YEAR

**SPECIMEN COLLECTION**

Date _____
MO / DAY / YEAR

Collector's Initials _____

Time: _____ ☐ AM ☐ PM

**BILLING**

☐ PHYSICIAN / ACCOUNT
☐ PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED

IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

| OR Room Number: | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Ordering Physician | | | |
| Additional Physicians(s) | | | |
| | | | |

**PLEASE CHECK:** ☐ **Routine** ☐ **Phone report** ☐ **STAT**

## TISSUE BIOPSY

**Please provide clinical history:**

_____
_____
_____
_____

**PREVIOUS BIOPSY:**
☐ Benign
☐ Suspicious
☐ HGPIN
☐ Adenocarcinoma

**PREVIOUS THERAPY:**
☐ Prostatectomy
☐ Radiation
☐ Cryotherapy
☐ Other:
_____
_____

**SPECIMEN:**
Time Placed in Formalin: _____
☐ Bladder
☐ Vas Deferens
☐ Prostate BX – Single or Multiple
☐ Prostate – Saturation Biopsies

**CLINICAL INFORMATION:**
PSA Last Result:_____
Date:_____
DRE/Clinical Stage:
☐ Non-palpable
☐ Palpable in ½ of one lobe or less
☐ Palpable in more than ½ of one lobe (but not both)
☐ Palpable bilaterally

☐ **PROSTATE – TRANSPERINEAL BIOPSIES**

| Left | Right |
|---|---|
| ☐ Posterior Medial | ☐ Posterior Medial |
| ☐ Posterior Lateral | ☐ Posterior Lateral |
| ☐ Base | ☐ Base |
| ☐ Anterior Medial | ☐ Anterior Medial |
| ☐ Anterior Lateral | ☐ Anterior Lateral |

☐ All Sources
☐ Other _____

# of Vials Submitted _____
Pre Op Diagnosis _____
Post Op Diagnosis _____

☐ **PROSTATE – TRANSRECTAL BIOPSIES**

| Left | Right |
|---|---|
| ☐ Base | ☐ Base |
| ☐ Mid | ☐ Mid |
| ☐ Apex | ☐ Apex |
| ☐ Lat Base | ☐ Lat Base |
| ☐ Lat Mid | ☐ Lat Mid |
| ☐ Lat Apex | ☐ Lat Apex |

☐ All Sources
☐ Other _____

# of Vials Submitted _____
Pre Op Diagnosis _____
Post Op Diagnosis _____

## CYTOLOGY

**SPECIMEN TYPE:**
☐ Voided Urine
☐ Cath. Urine
☐ Bladder Washings
☐ Post Cystoscopy Void
☐ Renal Washings ☐ Rt. ☐ Lt.
☐ Ureteral Washings ☐ Rt. ☐ Lt.
☐ Ileal Conduit
☐ Other _____

**Please provide clinical history:**

_____
_____
_____
_____

**If UroVysion FISH is being requested contact your reference lab.**

**A second urine sample must be collected & sent directly to your reference lab within 72 hours of collection.**