ACCU | REFERENCE MEDICAL LAB

1901 East Linden Ave, Suite 4, Linden, NJ 07036
Tel: 908-474-1004 • Fax: 908-474-0032
www.accureference.com

Specimen #

For Lab Use ONLY

UROLOGIC PATHOLOGY REQUISITION

REQUESTING PHYSICIAN

PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth *(Required)* ______/______/______ | Gender *(Req.)* M | F | Date Specimen Collected *(Req.)* ______/______/______

Street Address | Apt. #

City | State | Zip

Social Security # | Telephone #

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT AND BACK), OR FILL IN THE NECESSARY INFORMATION BELOW, THANK YOU

☐ **Check here if self-pay** (If checked, please attach the acknowledgment form)

☐ **Secondary insurance exists.** If checked, please include a photocopy of both carriers and clearly indicate primary and secondary.

Insurance Carrier: | Address | City | State | Zip

Name of Insured *(if different from patient)*: | Insurance ID: | Group #

DOB of Insured ______/______/______ | Gender M | F | Relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other ______

Diagnosis Code(s):

HISTOLOGY

Tests Required. Please check box.

☐ **Prostate Histology Only**

☐ **Prostate Histology with specific instructions** ______________

Bladder Histology

☐ **Biopsy Site 1** ☐ **Biopsy Site 3**

☐ **Biopsy Site 2** ☐ **Biopsy Site 4**

☐ **Penile Histology**

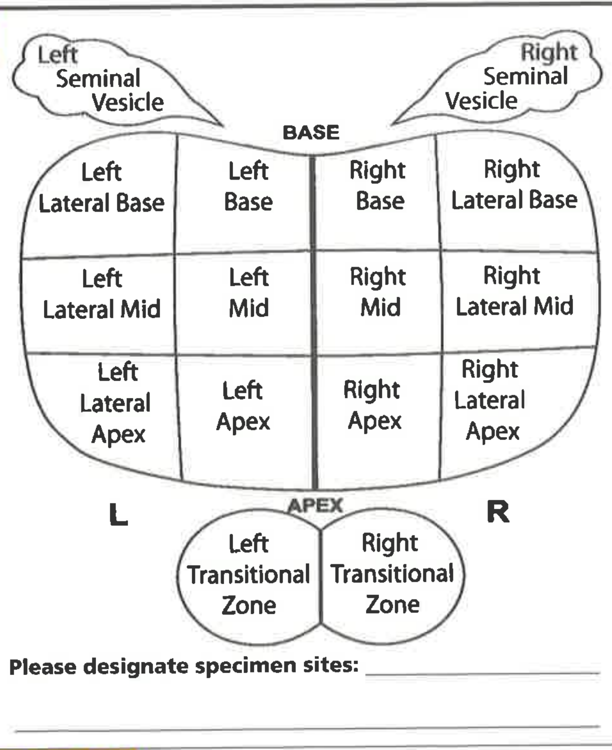
☐ **Testicular Histology - Infertility**

☐ **Testicular Histology - Other**

☐ **Vas Deferens**

☐ **Skin, specify site** ______________

☐ **Other** ______________



Please designate specimen sites: ______________

CLINICAL INFORMATION

Last PSA result __________ **ng/ml**

Date _____/_____/_____

DRE: ☐ **Normal** ☐ **Abnormal**

Abnormal findings: ______________

Previous biopsy: ☐ **None** ☐ **Benign** ☐ **Inflammation** ☐ **Atypia** ☐ **HPIN** ☐ **Malignant**

☐ **Other** ______________

Previous therapy: ☐ **None** ☐ **BCG** ☐ **Hormonal** ☐ **Chemotherapy** ☐ **Radiation** ☐ **Cryo/Surgery**

☐ **TCC History: Dx Date** ______________

☐ **Hematuria** ☐ **Dysuria**

☐ **Proteinuria** ☐ **Cystitis**

Physician's Signature *(required in NY, NJ, MA and PA)*

X ______________________________ Date ______________

NOTE: SPECIMEN CONTAINERS MUST INCLUDE PATIENT NAME AND BIOPSY SITE