MAINSTREAM
DIAGNOSTIC LABORATORY

UROLOGY

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INFORMATION

Last Name | First Name | M.I.

Street Address | Apt# | City | State | ZIP

Phone | SSN | D.O.B. | M ☐ F ☐

INSURANCE INFORMATION

Insurance Name | I.D. # | Group#

☐ Bill Medicare ☐ Bill Medicaid ☐ Bill Patient ☐ Bill Client

SPECIMEN INFORMATION

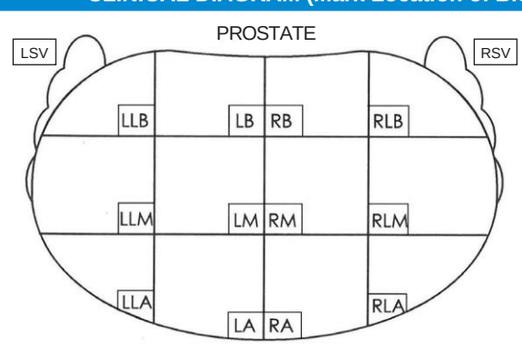
Date Collected: ___/___/_____ Time Collected: _____

Fasting: ☐ Yes ☐ No Fax results to: _____ ☐ STAT

CLINICAL INFORMATION – Check allthat apply

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

CLINICAL DIAGRAM (Mark Location of Biopsy(s))



CLINICAL & THERAPY HISTORY

PROSTATE

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

BLADDER

☐ TCC History: Dx Date:_____Grade:_____
☐ Hematuria ☐ TURB
☐ Dysuria ☐ BCG
☐ Proteinuria ☐ Mitomycin
☐ Cystitis ☐ 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 ☐ Penile Histology
☐ Testicular Histology-Infertility ☐ Skin (Specify Site)
☐ Testicular Histology-Other _____
☐ Vas Deferens ☐ 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 ☐ Bladder Wash
☐ Catheterized Urine ☐ Post Cystoscopy Voided Urine
☐ Illeal Conduit/Neobladder
☐ Upper Tract _____

Physician Signature:_____Date: _____

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

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