UROLOGY TEST REQUISITION

SBMF
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.