SMA Medical Laboratories

UROLOGY

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PATIENT 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

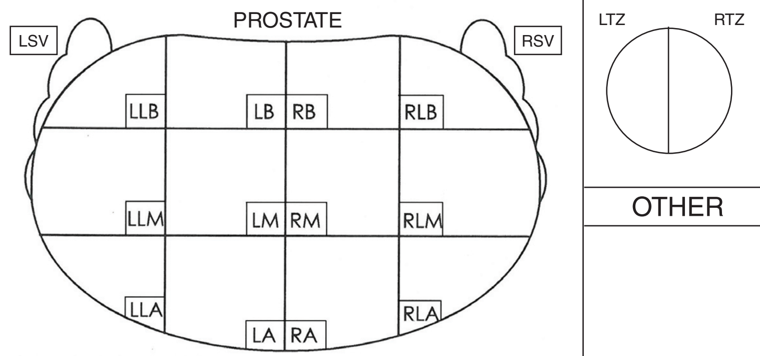
Date Collected:____/____/_______ Time Collected: ____________________

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

CLINICAL INFORMATION – Check 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		Other:

CLINICAL DIAGRAM (Mark Location of Biopsy(s))



CLINICAL & THERAPY HISTORY

PROSTATE

☐ Last PSA Result __________ Date _________
☐ D.R.E: Negative ☐ D.R.E. Suspicious
☐ Hypoechoic Lesion: Suspicious
☐ Hormone Therapy
☐ Prior Biopsy: Date: ____________________
Result: ☐ Benign ☐ Atyp/Susp.

☐ TURP
☐ Cryosurgery
☐ Radiation
☐ HIFU
☐ HGPIN ☐ Pca

BLADDER

☐ TCC History: Dx Date: ___________ Grade: ______________
☐ Hematuria
☐ Dysuria
☐ Proteinuria
☐ Cystitis

☐ TURB
☐ BCG
☐ Mitomycin
☐ Thiotepa

OTHER

TEST ORDERED

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

☐ **TECHNICAL PREPARATION ONLY**

OTHER PATHOLOGY
☐ Bladder Histology
☐ Testicular Histology-Infertility
☐ Testicular Histology-Other
☐ Vas Deferens

☐ **TECHNICAL PREPARATION ONLY**
☐ 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 ☐ 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