ACUPATH LABORATORIES, INC
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FAX# (516) 326-3452
28 S. Terminal Dr., Plainview, NY 11803

"FOR THE ABSOLUTE HIGHEST STANDARD IN HEMATOPATHOLOGY" © 2022

PROSTATE REQUEST FORM

PROS-01

ANY OMISSION MAY RESULT IN DELAY OF REPORT

NOT FOR PATIENT USE

PATIENT INFORMATION

SS# _____ DATE OF BIRTH _____ M☐ F☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL # (_____) _____ CHART # _____ PATH# _____

PHYSICIAN SIGNATURE: _____

COLLECTION INFORMATION

COLLECTION DATE:_____/_____/_____ **TIME:**_____:_____ ☐AM ☐PM

CLINICAL HISTORY:_____

Please add ICD-10 trailing digits on blank lines below.

☐ Prostate Nodule D40.0_____ ☐ Hx. of Prostate Cancer Z85.46/C61_____

☐ Elevated PSA R97.2_____

PROSTATE

Please add ICD-10 trailing digits on blank lines below.

☐ Prostate Nodule D40.0_____ ☐ Hx. of Prostate Cancer Z85.46/C61_____

☐ Elevated PSA R97.2_____

Required for Han & Partin Tables*:

*Pre-Biopsy PSA Result: _____

*DRE ***(for clinical stage info if biopsy is positive):***

☐ Normal (T1c) ☐ Abnormal, Unilateral ≤ 50% of lobe (T2a)

☐ Abnormal, Bilateral (T2c) ☐ Abnormal, Unilateral > 50% of lobe (T2b)

Prior Bx Findings: _____ ☐ PCA3: _____

Prior Rx: ☐ Hormone Therapy ☐ Radiation ☐ Cryosurgery

Age at Diagnosis: _____

DIAGNOSTIC TEST ORDER - *Mark Location of Biopsy(s)*

☐ Diagnostic Prostate Biopsy ☐ TURP ☐ Saturation Biopsy

☐ PINgenius™ reflex for HGPIN

☐ ConfirmMDX™ reflex for: ☐ Negative ☐ HGPIN

☐ Prognostic Panel for Localized Prostate Cancer

☐ PTEN/ERG ☐ oncotypeDX® ☐ Decipher ® ☐ Prolaris®

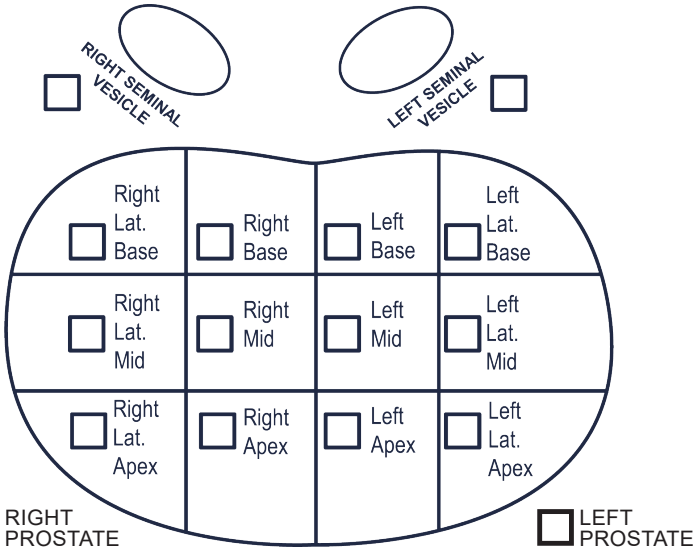
☐ All Gleason grades ☐ 3+3 ☐ 3+4 ☐ 4+3 ☐ ≥8

☐ knowerror®

For core with highest grade: ☐ Unilateral ☐ Bilateral

Signature Required: _____

REQUIRED
TOTAL # OF PROSTATE JARS SUBMITTED:



INSURANCE INFORMATION

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD(S), OR FILL OUT INSURANCE SECTION.

☐ **PATIENT'S PRIMARY INSURANCE** ☐ **SECONDARY INS.** ***(attach copies)***

☐ BILL TO MEDICARE ☐ BILL TO MEDICAID ☐ BILL TO INSURANCE ☐ BILL TO PATIENT

INSURED'S NAME_____ D.O.B._____/_____/_____

PT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURANCE CO:_____

POLICY #_____SS#_____-_____-_____

GROUP NAME:_____REFERRAL#_____

INSURANCE ADDRESS:_____

CITY_____STATE_____ZIP_____

TARGETED BIOPSIES WILL BE PUT ON THE FIRST PAGE OF THE PATHOLOGY REPORT.

WE WILL THEN DEFAULT TO OUR STANDARD ORDER UNLESS OTHERWISE SPECIFIED.

Disclaimer – De-identified patient data may be used for R&D purposes.