ACUPATH LABORATORIES, INC
WWW.ACUPATH.COM
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TEL# (516) 775-8103
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28 S. TERMINAL DR., PLAINVIEW, NY 11803

"FOR THE ABSOLUTE HIGHEST STANDARD IN UROPATHOLOGY"

UROPATHOLOGY TEST REQUEST FORM

UROUTI_02

ANY OMISSION MAY RESULT IN DELAY OF REPORT

PHYSICIAN SIGNATURE: _____

☐ **TC** ☐ **GLOBAL**

DATE OBTAINED: ___/___/_____

ICD-10 CODE(S): _____

☐ **STAT** ☐ CHECK MARGINS ☐ CALL MD W/ RESULTS

☐ **URINE CYTOLOGY & URO17 ICC STAIN**
☐ Reflex to UroVysion™ FISH if Urine Cytology is Atypical, Suspicious, or URO17 Positive

☐ **URINE CYTOLOGY & URO17 ICC STAIN & UROVYSION™ FISH**

☐ **URINE CYTOLOGY& UROVYSION™ FISH**

☐ **URINE CYTOLOGY WITH REFLEX**
- Reflex to UroVysion™ FISH if Urine Cytology is Atypical or Suspicious

☐ **URINE CYTOLOGY ONLY**

☐ **UROVYSION™ FISH ONLY**

☐ **URO17 ICC STAIN ONLY**

Collection Method:

☐ VOIDED URINE
☐ CATHETERIZED
☐ BLADDER WASHING
URETERAL WASHING: ☐ RT ☐ LT
URINE PELVIC WASHING: ☐ RT ☐ LT

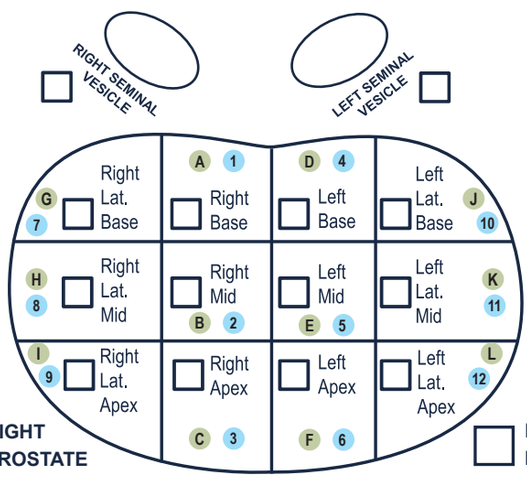
☐ **STANDARD URINARY TRACT INFECTION (UTI) TEST BY RT-PCR**

☐ **COMPREHENSIVE (UTI) TEST BY RT-PCR with STI PANEL**
- Clean Catch Urine Needed

BIOPSY*

☐ Prostate - # of Jars_____ # of Cores_____
☐ PTEN & ERG FISH ☐ PTEN FISH ☐ ERG FISH
☐ Bladder - # of Jars_____ ☐ Other - # of Jars_____
☐ HPV TISSUE (ISH) *If Screen +, do subtype (6/11, 16/18, 31/33)*
☐ Stone Analysis ☐ Location_____
Circle One: Spontaneous Passage / Surgical Removal / Lithotrips
☐ Other Test Request_____

** Includes IHC and special (billable) stains deemed necessary by Acupath pathologist*



☐ **RIGHT PROSTATE** ☐ **LEFT PROSTATE**

PATIENT INFORMATION

SS# _____ DATE OF BIRTH ___/___/_____ M ☐ F ☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

(_____) _____
TEL # CHART # PATH#

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION BELOW

PATIENT'S PRIMARY INSURANCE *(Secondary Ins. attach a copy of card)*

BILL TO: ☐ INSURANCE ☐ MEDICARE ☐ PATIENT ☐ OTHER ☐ NO FAULT ☐ WORKERS COMP

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

NAME OF INSURANCE CO:_____

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

POLICY #:_____

GROUP NAME:_____

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc. I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature _____

CLINICAL HISTORY

☐ Cancer (specify):_____

Other Clinical Data & Comments:_____

☐ **PARTIN TABLE ON REPORT** - ***Clinical Stage and PSA are Required***

Clinical Stage: ☐ T1 ☐ T2a ☐ T2b/T2c

PSA:_____ng/mL

PROSTATE - MOLECULAR TEST SENDOUTS

GLEASON SCORES:

☐ ALL ☐ 3+3 ☐ 3+4 ☐ 4+3 ☐ 4+4 ☐ ▲ Higher

PSA:_____ng/mL

POSITIVE PROSTATE BIOPSY:

☐ **Decipher® Prostate** ☐ **Confirm mdx GPS** (Genomic Prostate Score©) ☐ **Myriad Prolaris**

CONFIRM MDX
NEGATIVE BIOPSY
☐ **All cancer-negative** ☐ **Benign only**
☐ **Atypia only** ☐ **PIN only**

(REQUIRED)
PHYSICIAN SIGNATURE:_____

ADDITIONAL SITES:

☐ M 13 _____
☐ N 14 _____
☐ O 15 _____
☐ P 16 _____
☐ Q 17 _____
☐ R 18 _____

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

V092024