ACUPATH LABORATORIES, INC
WWW.ACUPATH.COM
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28 S. TERMINAL DR., PLAINVIEW, NY 11803

"FOR THE ABSOLUTE HIGHEST STANDARD IN UROPATHOLOGY"

UROPATHOLOGY TEST REQUEST FORM

ART-URO-01

ANY OMISSION MAY RESULT IN DELAY OF REPORT

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 the claim(s) and 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:_____

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

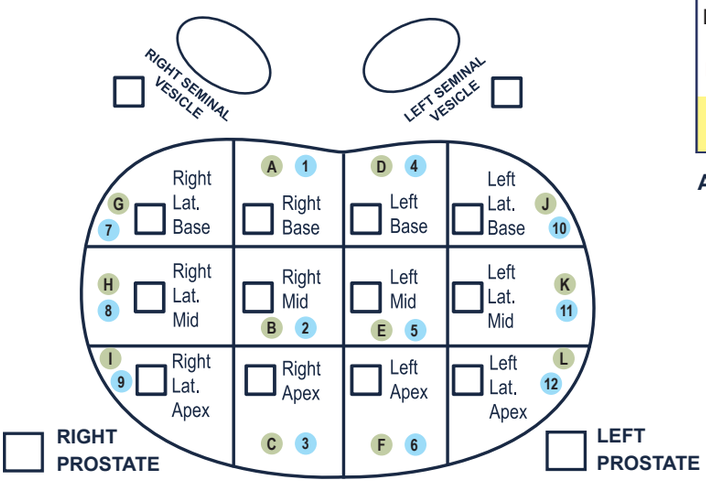
☐ **STANDARD URINARY TRACT INFECTION (UTI) TEST BY RT-PCR**

☐ **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**

CLINICAL HISTORY

☐ Cancer (specify):_____
Other Clinical Data & Comments:_____

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

REFLEX SENDOUTS

GLEASON SCORE: ☐ **ALL** ☐ **3+3** ☐ **3+4** ☐ **4+3** ☐ **4+4 or higher**

PSA: _____ **ng/mL**

Evidence of Distant Metastasis: Y / N

Prior Hormone Therapy?: Y / N

Clinical Stage: ☐ **T1c** ☐ **T2a** ☐ **T2b** ☐ **T2c** ☐ **T3a**

POSITIVE: ☐ **ArteraAI *** ☐ **Decipher® *** ☐ **GPS® *** ☐ **Prolaris® ***

** I confirm the patient has localized prostate cancer, an estimated life expectancy of ≥ to 10 years and has not received pre-procedure treatment.*

☐ **Vesta BCG Predict** ☐ **Vesta HG Risk Stratify**

NEGATIVE: **Confirm mdx** ☐ **All cancer-negative** ☐ **Benign only** ☐ **Atypia only** ☐ **HGPIN only**

PHYSICIAN SIGNATURE (required):_____

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.

V112025