SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

Uropathology Requisition

Phone: (888) 261-2671 www.sepalabs.com

CAP ACCREDITED

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PATIENT INFORMATION

Service Date: _____ Time Collected: ____ Ordering Physician: _____

Name (last, first, middle): _____

DOB: ___ , _____ , _____ Gender: ☐ M ☐ F SSN: _____ - _____ - _____

Address: _____ City: _____ Zip: _____

Contact Phone : ( ) _____ - _____ x _____

Responsible Party: Relationship:

ORDERING PHYSICIAN/FACILITY

BILLING INFORMATION

(Please attach patient face sheet and front and back of insurance card to ensure correct billing)

☐ Medicare ☐ Medicaid ☐ Client ☐ Patient ☐ Other (see attached)

Primary Insurance Name

Policy #:

Group #:

Secondary Insurance Name

Policy #:

Group #:

Patient/Chart # Date

ICD-9/10 Diagnosis Code(s)

Please provide a diagnosis code for all tests ordered that can be substantiated by the patient's medical record. Tests deemed not "MEDICALLY NECESSARY" must be accompanied by a signed ADVANCE BENEFICIARY NOTICE (ABN).

*PROVIDING A SOCIAL SECURITY # & DATE OF BIRTH IS ESSENTIAL TO LOCATE AND REVIEW PREVIOUS HISTOLOGY AND CYTOLOGY

Clinical Data

☐ PSA: _____ Date: _____

☐ Bladder Tumor

☐ Papillary lesion ☐ Erythema ☐ Thickening

☐ Thickening

☐ DRE: ☐ Normal ☐ Abnormal

☐ T1c ☐ T2a ☐ T2b/2c

Previous Biopsy: ☐ None ☐ Benign ☐ Inflammation ☐ Atypia ☐ HGPIN

☐ Malignant ☐ Other:

Previous Therapy: ☐ None ☐ Hormonal ☐ BCG ☐ Radiation ☐ Chemotherapy

☐ Cryosurgery ☐ Other:

☐ Hematuria

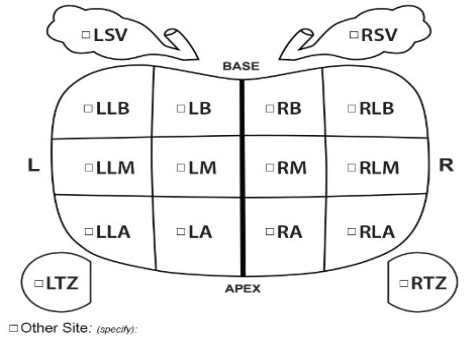
☐ History of Bladder Cancer

☐ Prostate Neoplasm

☐ Prostate Malignant Neoplasm

☐ Other: _____

_____



☐ Other Site: *(specify)*:

Procedure

☐ Biopsy

☐ Excision

☐ Stone Analysis

☐ Transurethral Resection

☐ Vasectomy

☐ Other:

Source

☐ Epididymis ☐ L ☐ R ☐ Both

☐ Kidney ☐ L ☐ R ☐ Bilateral

☐ Prostatic Urethra

☐ Seminal Vesicle ☐ L ☐ R ☐ Bilateral

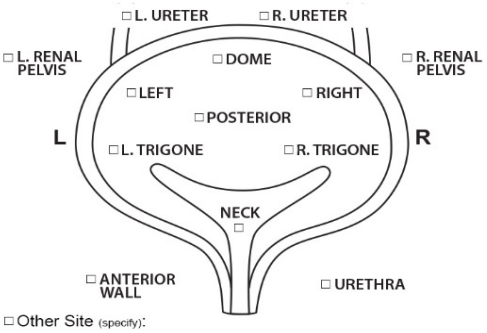
☐ Scrotum

☐ Testicle ☐ L ☐ R ☐ Bilateral

☐ Ureter ☐ L ☐ R ☐ Bilateral

☐ Urethra

☐ Vas Deferens ☐ L ☐ R ☐ Bilateral



☐ Other Site (specify):

Urine Cytology

Specimen (Required)

☐ Urine (*indicate collection method below*)

☐ Cath ☐ Voided ☐ Ileal Conduit

☐ Bladder Washing

☐ Renal Washing

Test Requests

☐ Cytology

☐ Cytology, reflex to FISH if Atypical

☐ Cytology, with FISH for Bladder Cancer

☐ FISH for Bladder Cancer

FOR LAB USE ONLY

Left Lateral Base 00000 Name:	Left Apex 00000 Name:	Right Mid 00000	Left Prostate 00000 Name:	Spermatic Cord 00000 ☐ L ☐ R ☐ B Name:
Left Lateral Mid 00000 Name:	Right Lateral Base 00000 Name:	Right Apex 00000 Name:	Prostatic Urethra 00000 Name:	Testicle 00000 ☐ L ☐ R ☐ B Name:
Left Lateral Apex 00000 Name:	Right Lateral Mid 00000 Name:	Left Transitional Zone 00000 Name:	Epididymis 00000 Name:	Kidney 00000 ☐ L ☐ R ☐ B Name:
Left Base 00000 Name:	Right Lateral Apex 00000 Name:	Right Transitional Zone 00000 Name:	Seminal Vesicle 00000 Name:	Ureter 00000 ☐ L ☐ R ☐ B Name:
Left Mid 00000 Name:	Right Base 00000 Name:	Right Prostate 00000 Name:	Scrotum 00000 Name:	Urethra 00000 Name:
Other: 00000 Name:	Other: 00000 Name:	Other: 00000 Name:	Urine Cytology 00000 Name:	UroVysion FISH 00000 Name:

P.E.T. Godbey, M.D., FCAP, Laboratory Director