



## UROLOGY REQUISITION

ACCESSION NO.  
\_\_\_\_\_

LAST NAME	FIRST NAME	MI	DOB	SEX	PHONE NUMBER
MAILING ADDRESS			CITY		STATE
ZIP CODE		RESPONSIBLE PARTY NAME			
SOCIAL SECURITY NUMBER					

<b>BILL TO:</b>  <table style="width: 100%;"> <tr> <td style="width: 15%;"><b>PRIMARY</b> <small>CHECK ONE</small></td> <td style="width: 15%;"><b>SECONDARY</b> <small>CHECK ONE</small></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>CLIENT</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>INSURANCE</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>MEDICARE</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>MEDICAID</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>OTHER _____</td> </tr> </table>	<b>PRIMARY</b> <small>CHECK ONE</small>	<b>SECONDARY</b> <small>CHECK ONE</small>		<input type="checkbox"/>	<input type="checkbox"/>	CLIENT	<input type="checkbox"/>	<input type="checkbox"/>	INSURANCE	<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<b>INSURANCE NAME AND ADDRESS:</b>  <hr/> <table style="width: 100%;"> <tr> <td style="width: 50%;">INSURANCE ID:</td> <td style="width: 50%;">GROUP NO.:</td> </tr> </table>	INSURANCE ID:	GROUP NO.:
<b>PRIMARY</b> <small>CHECK ONE</small>	<b>SECONDARY</b> <small>CHECK ONE</small>																				
<input type="checkbox"/>	<input type="checkbox"/>	CLIENT																			
<input type="checkbox"/>	<input type="checkbox"/>	INSURANCE																			
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE																			
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID																			
<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____																			
INSURANCE ID:	GROUP NO.:																				

*PLEASE ATTACH COPY OF INSURANCE CARD*

ORDERING PHYSICIAN:	COPY TO:	COLLECTION DATE:	ICD-9 CODE(S):
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<b>SIGNIFICANT CLINICAL HISTORY:</b>  	<b>CURRENT CLINICAL HISTORY:</b>  <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>PSA:</b>  <input type="checkbox"/> 0-2.5  <input type="checkbox"/> 2.6-4.0  <input type="checkbox"/> 4.1-6.0  <input type="checkbox"/> 6.1-10.0  <input type="checkbox"/> &gt; 10.0         </td> <td style="width: 50%; vertical-align: top;"> <b>CLINICAL STAGE:</b>  <input type="checkbox"/> T1c (nonpalpable)  <input type="checkbox"/> T2a (palpable &lt; 1/2 lobe)  <input type="checkbox"/> T2b (palpable &gt; 1/2 lobe)  <input type="checkbox"/> T2c (palpable both lobes)         </td> </tr> </table>	<b>PSA:</b> <input type="checkbox"/> 0-2.5 <input type="checkbox"/> 2.6-4.0 <input type="checkbox"/> 4.1-6.0 <input type="checkbox"/> 6.1-10.0 <input type="checkbox"/> > 10.0	<b>CLINICAL STAGE:</b> <input type="checkbox"/> T1c (nonpalpable) <input type="checkbox"/> T2a (palpable < 1/2 lobe) <input type="checkbox"/> T2b (palpable > 1/2 lobe) <input type="checkbox"/> T2c (palpable both lobes)
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1. LLB # of cores _____	4. LB # of cores _____	7. RB # of cores _____	10. RLB # of cores _____
2. LLM # of cores _____	5. LM # of cores _____	8. RM # of cores _____	11. RLM # of cores _____
3. LLA # of cores _____	6. LA # of cores _____	9. RA # of cores _____	12. RLA # of cores _____