SOUTHEASTERN PATHOLOGY

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URINARY CYTOLOGY REQUISITION

*Required Information - *Please Print*

Collection Date	Clinician	Additional Clinician (s)	Office Location

PATIENT

***Name** (Last) _____ (First) _____ (MI) _____ PT ID # _____

***SSN** _____ ***Date of Birth** _____ ***Sex:** ☐ M ☐ F

Patient Address _____ Phone _____

City _____ State _____ Zip _____

SPECIMEN(S)

Specimen 1:

☐ Voided Urine
☐ Cath. Urine
☐ Bladder Wash
☐ Renal Wash (R / L)
☐ Ileal Conduit / Pouch
☐ Instrumentation?
☐ Other _____

Specimen 2:

☐ Voided Urine
☐ Cath. Urine
☐ Bladder Wash
☐ Renal Wash (R / L)
☐ Ileal Conduit / Pouch
☐ Instrumentation?
☐ Other _____

CLINICAL HISTORY/RELEVANT PRIOR PATH

☐ TCC Current / History
☐ Hematuria
☐ Dysuria
☐ Cystitis
☐ Stones
☐ BcG Rx
☐ TURP
☐ Medication
☐ Radiation Rx
☐ Thiotepa
☐ Mitomycin
☐ UroVysion (FISH)
☐ Other: _____

Complete Insurance Information Below

DX codes:

PRIMARY INSURANCE

Member ID# / Policy # _____
Employer _____ Group # _____
Insured's Name _____ Relationship to Patient _____
Insured's SSN _____ Insured's DOB _____
Insurance Co. _____
Claims Address _____
City, ST Zip _____

PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE

SECONDARY INSURANCE

Member ID# / Policy # _____
Employer _____ Group # _____
Insured's Name _____ Relationship to Patient _____
Insured's SSN _____ Insured's DOB _____
Insurance Co. _____
Claims Address _____
City, ST Zip _____

PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE.

FOR SEP USE

88104_____Non-Gyn Smear
88108_____Cytospin
88112_____Non-Gyn ThinPrep
88173_____Fine Needle Asp
88305_____Cell block
88312_____organism stain
88313_____Histostain, other
88342_____Immuno Stain
88121_____UroVysion (FISH)

Additional testing may be performed if determined medically necessary to render a diagnosis in the opinion of the reviewing pathologist.

CASE #