SOUTHEASTERN PATHOLOGY

311 West 8th Street Rome, GA 30165

706-291-2430
800-225-8702
Fax: 706-290-0201
www.sepath.com

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 ☐ Ileal Conduit / Pouch

☐ Cath. Urine ☐ Instrumentation?

☐ Bladder Wash

☐ Renal Wash (R / L) ☐ Other _____

Specimen 2:

☐ Voided Urine ☐ Ileal Conduit / Pouch

☐ Cath. Urine ☐ Instrumentation?

☐ Bladder Wash

☐ Renal Wash (R / L) ☐ Other _____

CLINICAL HISTORY/RELEVANT PRIOR PATH

☐ TCC Current / History ☐ Other:

☐ Hematuria ☐ UroVysion (FISH)

☐ Dysuria

☐ Cystitis

☐ Stones

☐ BcG Rx

☐ TURP

☐ Medication

☐ Radiation Rx

☐ Thiotepa

☐ Mitomycin

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 88305_____Cell block

88108_____Cytospin 88312_____organism stain

88112_____Non-Gyn ThinPrep 88313_____Histostain, other

88173_____Fine Needle Asp 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 #