

IU Health System Pathology Laboratories 350 W. 11th Street, Room 5013

			HE.	Indian	na University He	317.4	napolis, IN 46202 91.6000 or 800.4 17.491.6001			
atient Legal Name (Last,	First MI)		DOB	2)	Date/Time of	Collection				
ient Social Security#	Race	M R#/Alternat	e Pt ID	- () ST	Phone Results	s To:				
nt Address Phone				Fax Results T	0:					
, State, Zip			M F	1 '	. PATIENT					
hysicians Signature	Order Date	Print Physicia	ns Name (F,MI,	L) fields must be c	ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (high fields must be complete to bill patient's insurance company. Specimen will be registered as parand bill will be the responsibility of the patient if required information is not provided.					
nt (Clinic/Physician) Info	rmation			Group Physici	ans		P rimary Ins	urance		
						Compan	y Name:			
						IU/Policy	# Gro	up#/Name		
						Insurance	e Co. Address:			
d Additional Report To:					City:	State/2	ip:			
					PolicyHo	Policy Holder Name:				
						Relations	ship to Patient:			
ce: Medicare will only p icare definition of "Med	-		deny	5) ICD Diagno (Enter ALL that		1	2	3		
nent for a test that the phening test. If a test is bei	-			4	5	6	7	8		
Previous Cytology	Other Clinical Date Exam: Date	□ None	_ □ Benign □ <i>A</i> □ None □ Be	nign 🛮 Atypia	normal N	gnant □ Other				
□ Elevated PSA (79 □ Abnormal Prostate □ Prostate Nodule □ Prostate Cancer	90.93) te Exam (236 (600.1)	□ H .5) □ H	lematuria (59 listory of Blac	9.7) Ider Cancer (V er Neoplasm (2	10.51)	□ Acute Cystitis □ Interstitial Cys □ Chronic Cysti □ Other (ICD-9)	(595.0) stitis (595.1) tis (595.2)			
□ Cytology Check Source(s) (Required) □ Urine Cytology □ Other □ □ Prostate SpecType/Volume □ ml □ VU (voided urine) □ PVC (post cysto voided urine) □ PVC (post cysto voided urine) □ BW (bladder wash) □ Renal Wash L R □ Ureteral Wash L R □ Neo Bladder (Ileal conduit) Other □ Biopsy Check Source(s) (Required) □ Prostate □ Bladder □ Vas Deferens □ Stone □ Seminal Vesicle □ Second Opinion: □ Other □ Other					Please check all vials with site ap L base L lateral bas L mid L lateral mid L apex L lateral ape L transition	L lateral base R lateral base L mid R mid L lateral mid R lateral mid L apex R apex L lateral apex R lateral apex L transition zone R transition zone L seminal vesicle R seminal vesicle Left Right				
Omer										



IU Health System Pathology Laboratories 350 W. 11th Street, Room 5013 Indianapolis, IN 46202-4108 317.491.6000 or 800.433.0740 Fay: 317.491.6001

			HEALTH	maiama	CIIIV	317.491.6000 or 800.433.0740 Fax: 317.491.6001		
1) Patient Legal Name (Last, First M I) DOB			2)		Date/Time of Collection			
Patient Social Security#	Race	M R#/Alternat	e Pt ID	⊣()ST	ΑТ	Phone Results To:		
Patient Address		Phone		1		Fax Results To:		
City, State, Zip			M F	4)	В	BILL FACILITY / CLIENT		
3) Physicians Signature	Order Date	Print Physician	. , .	() Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid Attention PFN: do not register, send patient directly back to lab				
Client (Clinic/Physician) Information				Group Phys				
Send Additional Report To:				_				
Section 5 above. PSANG/µL Abnormal Findings/Oti Previous Biopsy: Dai	n: Respond be Date ner Clinical His	elow and/or attactions tory □ None □ Be	ch patient's mos DRE: □ Norm enign □ Atypia	st recent clin	nal Maligr	atory Surg Center history. Please provide ICD Diagnosis Codes in Cystoscopy: Normal Abnormal gnant Other Oth		
Previous Therapy:	None Horm	ional 🗆 BCG	□ Radiation □ 0	Chemotherap	y \Box C	Cryosurgery □ Surgery □ Other		
 □ Elevated PSA (790.93) □ Abnormal Prostate Exam (236.5) □ Prostate Nodule (600.1) □ Prostate Cancer (185) □ Hematuria (599.7) □ History of Bladder Ca □ Benign Bladder Neop □ Renal Cancer (189) 						□ Acute Cystitis (595.0)□ Interstitial Cystitis (595.1)□ Chronic Cystitis (595.2)□ Other (ICD-9)		
□ Cytology Check Source(s) (Re	quired)	□ Biopsy Check Source(vials	Prostate Biopsy Specimen Sites ase check all sites that apply. Make sure to label s with site appropriate label. L base R base			
□ Other	d urine)				L	L lateral base L mid L lateral mid L apex L lateral apex L transition zone R lateral base R mid R lateral mid R lateral apex R apex R lateral apex R transition zone		
□ Ureteral Wash L_ □ Neo Bladder (Ileal o	R onduit)					L seminal vesicle Left R seminal vesicle Left Right er		
Referring Physician Urologist:	nformation: (Fax	ax a final Report? YesNo		
Address:	Address:City, State, Zip				Fano			