siParadigm
diagnostic informatics

Issued Oct 2021
Any omission may result in delay of reporting

UROPATHOLOGY TEST REQUISITION FORM

PATIENT INFORMATION

Name _____ , _____ , _____
LAST FIRST MIDDLE

DOB / /

Gender at birth ☐ Male ☐ Female

Street _____

City _____ State _____ ZIP _____
5 DIGITS

MRN/Pt. ID/SSN # _____ Phone # _____

BILLING INFORMATION

☐ Insurance ☐ Client ☐ Patient Self-pay ☐ Hospital Inpatient
☐ Hospital Outpatient ☐ Non-Hospital Patient

ATTACH CLINICAL NOTES, PATIENT INFORMATION, CBC, AND INSURANCE CARD

I am certified to order the test(s) listed below, such that these test(s) are medically necessary and I have obtained informed consent for the requested test(s) when pertinent

Authorized Signature _____
Date _____/_____/_____

CLINICAL INFORMATION / HISTORY (HX) REQUIRED

Previous PSA _____ Previous % Free PSA _____

☐ HX of Urothelial Carcinoma
☐ HX of Urinary Tract Infection
☐ HX of Chemotherapy / Radiation
☐ BCG

☐ Previous Biopsy Results
_____
_____

ICD10 _____ Other Clinical Data _____
_____

RACE & ETHNICITY (Only required for CA patients)
_____

CLINICAL IMPRESSION

☐ Cancer ☐ Other, Please Specify _____

TEST REQUEST

☐ **siPortfolio Prostate Comprehensive Evaluation**
SIPARADIGM uropathologists will choose all IHC, special (Billable) stains and FISH testing as deemed medically necessary to render a comprehensive diagnosis of adenocarcinoma of the prostate and to further provide prognostic information, unless otherwise indicated by ordering physician in test request section above.

☐ Histology Includes IHC and special (billable) stains determined by pathologist

URINE CYTOLOGY

☐ Voided Urine
☐ Catheterized Urine
☐ Bladder Washing

Ureteral Washing ☐ RT ☐ LT
Pelvic Washing ☐ RT ☐ LT

☐ **HPV on tissue (ISH) with subtyping (6/11, 16/18, 31/33)**

INDIVIDUAL FISH PANELS

☐ UROVYSION™ (For Bladder Cancer Detection)
☐ PTEN (For Prostate Cancer Prognosis)
☐ ERG FISH (For Prostate Cancer Prognosis)
☐ Other Tests _____

SPECIMEN INFORMATION

☐ # Of Specimen Bottles _____
☐ # Paraffin Blocks _____
☐ Positive Slides

☐ # Cores
☐ Previous Biopsy

Biopsy Site / ☐ **See Diagram on Right**

☐ **Perform Cytospin If Necessary**

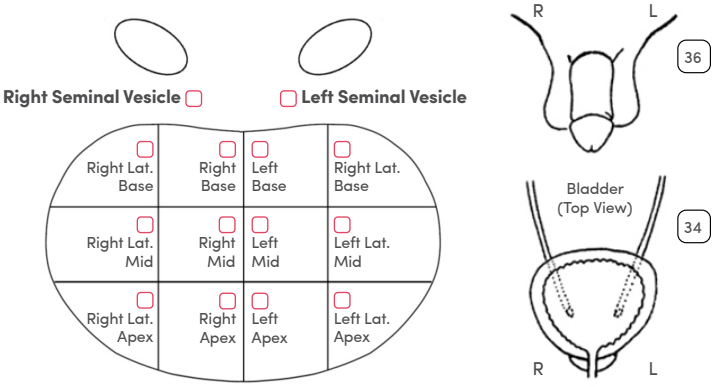
A	G
B	H
C	I
D	J
E	K
F	L

PHYSICIAN INFORMATION

Physician signature _____
Duplicate report to _____

☐ **STAT**

Date obtained / /
☐ Check margins ☐ Call MD w/ results



☐ **Right Prostate** ☐ **Left Prostate** **Additional Site(s)** ☐ _____
☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD

Right Base	**Right Lat Base**	
Right Mid	**Right Lat Mid**	
Right Apex	**Right Lat Apex**	
Left Base	**Left Lat Base**	
Left Mid	**Left Lat Mid**	
Left Apex	**Left Lat Apex**	

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CLIA CERTIFIED cap ACCREDITED

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