Urologic Pathology

True Partners in Laboratory Diagnostics

UR 1036

Alliance Laboratories of Westchester
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Tel 914-517-2485 Fax 914-345-3064

PATIENT INFORMATION

Last Name	First Name	
Address		Apt #
City	State	Zip Code
Phone	Sex / Age / DOB	
Social Security#	Medical Record#	

COLLECTION INFORMATION

Collection
Date: ____/____/____
Time: ____:____ am/pm

LAB USE ONLY

Case #: _____
Date Received: ____/____/____
Time Received: _____

BILLING INFORMATION

Name of Insured
Company Name
Street Address

City	State	DOB
Policy #	Group #	
Medicare/ Medicaid #	Referral #	

ACCOUNT INFORMATION

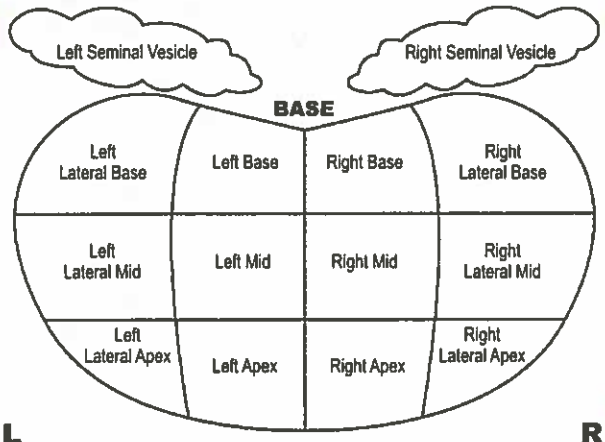
PRE-OPERATIVE Dx. (Clinical History)

- ☐ C67.9 Malignant neoplasm of bladder
- ☐ D30.3 Benign neoplasm of bladder
- ☐ D09.0 Carcinoma *in situ* of bladder
- ☐ R31.9 Hematuria
- ☐ R97.20 Elevated PSA
- ☐ N40.0 BPH
- ☐ C61 Malignant neoplasm of prostate
- ☐ Other: _____ **ICD-10 code** _____

HISTOLOGY

Test(s) required. Please check box.
Tissue type: _____
☐ Prostate (Identify on Diagram)
☐ Bladder histology
1. _____
2. _____
3. _____
☐ Vas deferens
☐ #1 R or L ☐ #2 R or L
☐ Other _____

☐ Second Opinion _____



CYTOLOGY

Specimen: Urine

Test(s) required. Please check box

- ☐ Cytology
- ☐ UroVysion
- ☐ Chlamydia/Gonorrhea
- ☐ Cytology + UroVysion
- ☐ Cytology + Chlamydia/Gonorrhea
- ☐ Cytology + UroVysion + CT/GC

CLINICAL INFORMATION

PSA_____ng/ml Date _____
DRE: ☐ Normal ☐ Abnormal
Abnormal findings: _____
Previous biopsy: ☐ None ☐ Benign ☐ Malignant
☐ Atypia ☐ HPIN
☐ Other _____
Previous therapy: ☐ None ☐ Hormonal ☐ BCG
☐ Radiation ☐ Chemotherapy ☐ Cryosurgery
☐ Surgery ☐ Other _____

CLINICAL INFORMATION

Cystoscopy: ☐ Normal ☐ Abnormal
Abnormal findings: _____
Previous cytology exam: Date _____
☐ None ☐ Benign ☐ Malignant
☐ Other _____
Previous therapy:
☐ None ☐ BCG ☐ Radiation ☐ Chemotherapy ☐ Surgery
☐ Other _____

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Non-Medicare Patients: I hereby authorize Alliance Laboratories of Westchester to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories of Westchester. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____