MEDPROLAB
4117 South St., Lakewood, CA 90712
Tel: (562) 723-6732
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CLIA 5D232518

STAFF USE
ACCESSION NO:

URINE COLLECTION		
DATE:	TIME:	AM PM

REQUISITION FORM FOR BLADDER CANCER SCREENING

PATIENT INFORMATION

Name: Last	First	Middle	Tel:

Date of Birth:	Age:	Sex:	Ethnicity:

Address:

PRESCRIBING PHYSICIAN INFORMATION

Physician:	Practice Name:

Address:

Tel:	Fax:

NPI:	Physician Sig:

Referring Physician:	Tel:

BILLING INFORMATION (attach copy of insurance card-both sides)

BILL ☐ My Account ☐ Insurance ☐ Medicare ☐ Medical ☐ Other

Primary Insurance:

ID #:	Group #:

Address:

Tel:	Relationship to Patient:

Job:	Employer:

Secondary Insurance:

ID #:	Group #:

Address:

Tel:	Relationship to Patient:

Job:	Employer:

CLINICAL INFORMATION

Indications:

☐ Age > 50yrs	☐ Urination pain or difficulty	☐ Smoking, drinking or drug history	☐ Possible bladder mass/thickening
☐ Hematuria	☐ High Urine Sediment	☐ Indeterminate / suspicious cystoscopy	☐ Urinary Tract Infection/disease
☐ Bladder Pain, discomfort	☐ Previous Bladder Cancer	☐ Relative with bladder cancer (who?)	☐ Other - describe below

OTHER DATA / ICD:

REF CPT 88112, 88341, 88342