SUBMITTING PHYSICIAN INFORMATION

Imgen Diagnostics

Phone 781.702.6940 • Fax 781.702.6941
129 Morgan Drive • Norwood, MA 02062

PATIENT INFORMATION

Date of Birth	Sex ☐ Male ☐ Female	
Patient Name (Last, First, Middle Initial)		
Address		
City	State	ZIP Code
Phone Number		
Medical Record Number (Optional)		

BILLING INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Name of Insured	Name of Insured
Patient's Relationship to Insured ☐Self ☐Spouse ☐Dependent	Patient's Relationship to Insured ☐Self ☐Spouse ☐Dependent

SPECIMEN INFORMATION

DATE OF PROCEDURE:_____ PHYSICIAN SIGNATURE: _____

Physician authorizes Imgen Diagnostics, Inc. to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

Please write patient name and DOB on all specimen bottles

URINE

- ☐ Urine for Molecular Urinary Tract Infection panel with Antibiotic Resistance Markers
- ☐ Urine for Molecular Vaginitis panel
- ☐ Urine for Cytology*
  - ☐ *If Urine Abnormal Reflex to FISH
- ☐ Urine for FISH analysis
- ☐ Voided Urine ICD-10:_____
- ☐ Washing ICD-10:_____
- ☐ Catheterized Urine ICD-10: _____

BIOPSY

- ☐ Bladder Biopsy ICD-10:_____
- ☐ Vas Deferens (Left) ICD-10:_____
- ☐ Vas Deferens (Right) ICD-10: _____
- ☐ Other Biopsy ICD-10: _____
- ☐ Pre-Biopsy Rectal Swab for Molecular Antibiotic Resistance Markers ICD-10: _____

Prostate Biopsy (For all 12 biopsies, check standard. For additional biopsies, complete additional labels.)

☐ Standard	☐ Left Apex	☐ Left Lateral Apex	☐ Right Apex	☐ Right Lateral Apex	☐ Left Mid	☐ Left Lateral Mid	☐ Right Mid	☐ Right Lateral Mid	☐ Left Base	☐ Left Lateral Base	☐ Right Base	☐ Right Lateral Base	☐	☐	☐	☐	☐
	LA	LLA	RA	RLA	LM	LLM	RM	RLM	LB	LLB	RB	RLB					

SPECIMEN INFORMATION

DATE OF PROCEDURE: _____	PSA RESULT: _____	ICD-10: _____