Emeritus MEDICAL TECHNOLOGY

☐ EMERITUSDX
12 SPECTRUM POINTE DRIVE | LAKE FOREST, CA 92630

☐ FREEDOM PATHOLOGY PARTNERS
524 EAST ELM STREET | CONSHOHOCKEN, PA 19428

Lab Use Only

**800-959-2846 | Fax: 949-418-7287**

# UROLOGY

## CLIENT INFORMATION *PLEASE CHECK REQUESTING PHYSICIAN*

**CHECK ONE:** ☐ TC ONLY ☐ GLOBAL ☐ CONSULTATION ☐ HOME KIT

## BILLING INFORMATION ☐ *See Attached*

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: _____ Policy #:_____ Group #: _____

Ins. Address: _____ City: _____ State: ____ Zip: _____

Policy Holder: _____ DOB: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: _____ Policy #:_____ Group #: _____

Ins. Address: _____ City: _____ State: ____ Zip: _____

## PATIENT INFORMATION *(Green highlighted sections are required information)*

*Please attach patient face sheet and front and back of primary and secondary insurance card:* ☐ *See Attached*

**REQUIRED**

**Name (Last, First):**_____

**Date of Birth:** ___/___/___ Sex: M F SS#_____

Address: _____

City: _____ State:____ Zip:_____

Home Phone #: _____ Work Phone #: _____

Medical Record #: _____

## CLINICAL INFORMATION

**COLLECTION DATE:**_____/_____/_____

*Clinical History:* _____

_____

I hereby authorize the release to the laboratory of any medical and insurance information necessary to process claims for services provided by the laboratory. I hereby authorize the laboratory to pursue all necessary appeals of full or partial denials of payment in relation to services provided by the laboratory.

**Patient Signature:** _____

## ICD-10 CODES

**Physician is required to (1) submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity, or (2) explain and have the patient sign an ABN.**

**Failure to provide ICD-10 code(s) will delay processing of the specimen.** Listed below are commonly used ICD-10 codes, check codes that apply or list codes in the space provided to support the test request(s).

### PROSTATE

- ☐ R97.20 Elevated PSA
- ☐ N41.1 Chronic Prostatitis
- ☐ N41.0 Acute Prostatitis
- ☐ N41.9 Inflammatory disease of prostate, unsp.
- ☐ C61 Malignant neoplasm of prostate
- ☐ D40.0 Neoplasm of uncertain behavior of prostate
- ☐ R97.21 Rising PSA following treatment for malignant neoplasm, prostate
- ☐ Z85.46 Personal hx malignant neoplasm, prostate
- ☐ Z30.2 Encounter for sterilization
- ☐ D41.4 Neoplasm of uncertain behavior of bladder
- ☐ N40.2 Nodular prostate without lower urinary tract symptoms
- ☐ N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms

### BLADDER/URINE

- ☐ N39.0 Urinary tract infection
- ☐ Z87.440 History of UTI (recurrent, persistent, or complicated UTI)
- ☐ R31.29 Other microscopic hematuria
- ☐ N30.00 Acute cystitis w/o hematuria
- ☐ R31.1 Benign microscopic hematuria
- ☐ N20.0 Calculus of kidney
- ☐ R30.0 Dysuria
- ☐ R31.0 Gross hematuria
- ☐ R31.9 Hematuria, unsp.
- ☐ C67.9 Malignant neoplasm bladder
- ☐ G89.29 Other chronic pain
- ☐ N30.20 Other chronic cystitis without hematuria
- ☐ R82.99 Other abnormal findings in urine
- ☐ Z85.51 Personal hx malignant neoplasm, bladder
- ☐ Z11.3 Screen for infections w/ sexual mode of transmission
- ☐ Z11.8 Screen for other infection I parasitic diseases
- ☐ Other _____

## UTIDX® FOR SYMPTOMATIC URINARY INFECTIONS

**UTIDX® UTI TEST** - *Order test by selecting collection method* *AST = Antibiotic susceptibility testing*

☐ Voided Urine ☐ Catheterized Urine ☐ Post Massage Urine ☐ Semen ☐ Other:_____

(BACTERIA, BACTERIAL GROUPS, YEAST, ABR GENES) *Test details on back*

- ☐ UTIDX® (PCR Detection with AST)
- ☐ UTIDX® and STIDX
- ☐ URINALYSIS
- ☐ VIRALDX (ADDITIONAL SPECIMEN TUBE REQUIRED)
- ☐ URINALYSIS, UTIDX® & BLADDER17®
- ☐ UTIDX® F-AST (Same Day Results PCR Detection without AST)
- ☐ PROSTATITIS
- ☐ STIDX (ADDITIONAL SPECIMEN TUBE REQUIRED)
- ☐ PRE-PROSTATE BIOPSY Rectal Swab (PPBRS)

IS PATIENT ON ANTIBIOTICS ☐ Yes ☐ No PREGNANT ☐ Yes ☐ No

ALLERGIES:_____

## HISTOLOGY

**PROSTATE** ☐ Needle Core Biopsy ☐ Fusion Biopsy* ☐ TURP ☐ Other: _____

**For Fusion Biopsy, please list number of cores for ROI in table below*

Previous Biopsy: ☐ Benign ☐ Suspicious/ASAP ☐ HGPIN ☐ Malignant ☐ None

DRE: ☐ Normal ☐ Abnormal Clinical Stage: ☐ T1c ☐ T2a ☐ T2b ☐ T2c ☐ T3

Last PSA: _____ ng/ml Date:_____/_____/_____

| LEFT APEX | LEFT LATERAL APEX | LEFT MID | LEFT LATERAL MID | LEFT BASE | LEFT LATERAL BASE | SITE: | SITE: |
|---|---|---|---|---|---|---|---|
| #: | #: | #: | #: | #: | #: | #: | #: |
| RIGHT APEX | RIGHT LATERAL APEX | RIGHT MID | RIGHT LATERAL MID | RIGHT BASE | RIGHT LATERAL BASE | SITE: | SITE: |
| #: | #: | #: | #: | #: | #: | #: | #: |

## BLADDER & OTHER HISTOLOGY

**COLLECTION METHOD**

☐ TURBT ☐ Cold Cup Biopsy ☐ Excision ☐ Other:_____

**SITE**

☐ Bladder-Site(s): _____

☐ Vas Deferens: ☐ Right ☐ Left

☐ Other:_____

☐ Consult Request - Please include all Case Slides

## URINE CYTOLOGY & BLADDER FISH

**COLLECTION METHOD**

☐ Voided Urine ☐ Bladder Wash ☐ Cystoscopy ☐ Other:_____

**TEST ORDER**

☐ Bladder FISH ☐ Bladder17® ☐ ProExC ☐ Feulgen ☐ Urinalysis

☐ Microscopy

- ☐ **Urinalysis Reflex:** Bladder FISH[1]

☐ Cytology

- ☐ **Cytology Reflex:** Bladder FISH[1]

[1] *FISH reflex based on the presence of RBCs, urothelial cell clusters, atypia, suspicious or positive cytology*

☐ **Comprehensive**

- ☐ Urinalysis, Cytology, Bladder17®, Bladder FISH, ProExC, Feulgen

## MOLECULAR

**COLLECTION METHOD**

☐ Voided Urine ☐ Bladder Wash ☐ Cystoscopy ☐ Other:_____

☐ Tissue/Block ☐ Swab ☐ Aptima Tube

- ☐ UroSense™ *(details on back)*
- ☐ FGFR therascreen® (tissue)
- ☐ WoundDX
- ☐ CT/NG C. trachomatis & N. gonorrhoerea
- ☐ Trichomonas Vaginalis
- ☐ Bacterial Vaginosis
- ☐ Candida Vaginitis/Trichomonas Vaginalis
- ☐ Mycoplasman Genitalium

## FISH

**COLLECTION METHOD**

☐ Tissue ☐ Block

- ☐ PTEN
- ☐ ERG
- ☐ PTEN and ERG

## IHC

- ☐ PIN4
- ☐ PTEN
- ☐ ERG
- ☐ PDL-1
- ☐ Other

## ADDITIONAL TESTS

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

**Physician/Authorized Signature**_____ **Date** _____/_____/_____

*Signature required on this order or in the patient's medical record*

**Please Discard Extra Labels**

1-Complete all required information on requisition. 2-Use appropriate number of labels provided. 3-Place 1 label on each specimen container (not on lid).

| | | | | | |
|---|---|---|---|---|---|
| Left Lateral Base<br>Name_____<br>DOB_____ | Left Lateral Base #2<br>Name_____<br>DOB_____ | Left Base<br>Name_____<br>DOB_____ | Right Base<br>Name_____<br>DOB_____ | Right Lateral Base<br>Name_____<br>DOB_____ | Right Lateral Base #2<br>Name_____<br>DOB_____ |
| Left Lateral Mid<br>Name_____<br>DOB_____ | Left Lateral Mid #2<br>Name_____<br>DOB_____ | Left Mid<br>Name_____<br>DOB_____ | Right Mid<br>Name_____<br>DOB_____ | Right Lateral Mid<br>Name_____<br>DOB_____ | Right Lateral Mid #2<br>Name_____<br>DOB_____ |
| Left Lateral Apex<br>Name_____<br>DOB_____ | Left Lateral Apex #2<br>Name_____<br>DOB_____ | Left Apex<br>Name_____<br>DOB_____ | Right Apex<br>Name_____<br>DOB_____ | Right Lateral Apex<br>Name_____<br>DOB_____ | Right Lateral Apex #2<br>Name_____<br>DOB_____ |
| Left Lateral Transitional<br>Name_____<br>DOB_____ | Left Seminal Vesicle<br>Name_____<br>DOB_____ | Left Transitional<br>Name_____<br>DOB_____ | Right Transitional<br>Name_____<br>DOB_____ | Right Lateral Transitional<br>Name_____<br>DOB_____ | Right Seminal Vesicle<br>Name_____<br>DOB_____ |
| Bladder Biopsy Site:<br>Name_____<br>DOB_____ | Bladder Biopsy Site:<br>Name_____<br>DOB_____ | Urine<br>Name_____<br>DOB_____ | Vas Deferens Left<br>Name_____<br>DOB_____ | Vas Deferens Right<br>Name_____<br>DOB_____ | Other:<br>Name_____<br>DOB_____ |

## UTIDX® UTI TEST ID, ABR & AST

**Urine based test designed to identify pathogens commonly associated with recurrent and persistent urinary tract infections while determining the best treatment options for the patient.**

- **Bacterial and Yeast Organisms** *Details listed below*
- **Bacterial Groups** *Details listed below*
- **Genotype Antibiotic Resistance Genes** *Details listed below*

## UTIDX® F-AST UTI TEST ID, ABR

**PCR detection of pathogens and antibiotic resistant genes without the antibiotic sensitivity testing that is included with UTIDX™**

- **Bacterial and Yeast Organisms** *Details listed below*
- **Bacterial Groups** *Details listed below*
- **Genotype Antibiotic Resistance Genes** *Details listed below*

### ORGANISMS TESTED:

### BACTERIAL AND YEAST ORGANISMS (*Fastidious Organisms)

- Acinetobacter baumannii
- Actinobaculum schaalii *
- Aerococcus urinae *
- Alloscardovia Omnicolens *
- Candida albicans *
- Candida auris *
- Candida glabrata *
- Candida parapsilosis *
- Citrobacter freundii
- Citrobacter koseri
- Coagulase Negative Staph
- Corynebacterium riegelii *
- Enterobacter aerogenes
- Enterobacter cloacae
- Enterococcus faecalis
- Enterococcus faecium *
- Escherichia coli
- Klebsiella oxytoca
- Klebsiella pneumoniae
- Morganella morganii
- Mycoplasma hominis *
- Pantoea agglomerans
- Proteus mirabilis
- Proteus vulgaris
- Providencia stuartii
- Pseudomonas aeruginosa
- Serratia marcescens
- Staphylococcus aureus
- Streptococcus agalactiae
- Ureaplasma urealyticum *
- Viridans Group Strep *

### GENOTYPE ANTIBIOTIC RESISTANCE GENES (38 Genes)

- AMPICILLIN
- CARBAPENEM
- EXTENDED SPECTRUM BETA-LACTAMASE
- METHICILLIN
- QUINOLINONE/FLUOROQUINOLONE
- VANCOMYCIN

## STIDX

**Urine based test designed to identify organisms commonly associated with sexually transmitted infections.**

### ORGANISMS TESTED

- Trichomonas Vaginalis
- Neisseria Gonorrhoeae-1
- Neisseria Gonorrhoeae-2
- Chlamydia Trachomatis
- Gardnerella Vaginalis
- Treponema pallidum (Syphilis)

## VIRALDX

### ORGANISMS TESTED

- Trichomonas Vaginalis
- Neisseria Gonorrhoeae-1
- Neisseria Gonorrhoeae-2
- BK Virus
- Chlamydia Trachomatis
- JC Virus
- Gardnerella Vaginalis
- Treponema pallidum (Syphilis)

## BLADDER FISH

**For initial diagnosis of bladder carcinoma in patients with hematuria and subsequent monitoring for tumor recurrence in patients previously diagnosed with bladder cancer.**

### GENES TESTED:

- CEP3
- CEP7
- CEP17
- 9p21

## UroSense™

**Urosense™ is a liquid biopsy FGFR3 mutation test to determine the presence or absence of bladder cancer and to facilitate the monitoring of tumor load.**

## Bladder17®

**Non-invasive urine test that provides sensitivity and specificity to significantly improve the early diagnosis and treatment of bladder cancer.**