Inform Diagnostics Prostate Fusion Biopsy Requisition

10000

Inform Diagnostics observes all standing orders for clients that have signed an Advanced Protocols Form.

PATIENT INFORMATION Shaded fields are required

Last Name	First Name	MI

Street Address	Apt #

City	State	Zip

Patient Phone #	Patient Work Phone #

Patient ID # (Driver's License/State ID)	Patient Medical Record #

Date of Birth / /	Age	Sex at Birth

ANCESTRY *Check all that apply*

❍ White/Caucasian (specify region) ❍ Western/Northern Europe ❍ Central/Eastern Europe ❍ Ashkenazi Jewish ❍ Native American
❍ Hispanic/Latino ❍ Black/African American ❍ Asian ❍ Middle Eastern ❍ Pacific Islander ❍ Other_____

BILLING INFORMATION

Complete billing information on reverse side or attach copy of front and back of patient's card. We file all primary and secondary insurance plans if information is provided.

COLLECTION INFORMATION & HISTORY

Date of Collection / /	Time of Collection _____ AM _____ PM	Clinical History

PROSTATE

Please add ICD-10 trailing digits on blank lines below.

❍ Prostate Nodule D40.0_____ ❍ Hx. of Prostate Cancer Z85.46/C61_____
❍ Elevated PSA R97.2_____

Required for Han & Partin Tables*:

*Pre-Biopsy PSA Result: _____

*DRE *(for clinical stage info if biopsy is positive)*:

❍ Normal (T1c) ❍ Abnormal, Unilateral ≤ 50% of lobe (T2a)
❍ Abnormal, Bilateral (T2c) ❍ Abnormal, Unilateral > 50% of lobe (T2b)

Prior Bx Findings: _____ ❍ PCA3: _____

Prior Rx: ❍ Hormone Therapy ❍ Radiation ❍ Cryosurgery

Age at Diagnosis: _____

DIAGNOSTIC TEST ORDER — Mark Location of Biopsy(s)

❍ Diagnostic Prostate Biopsy ❍ TURP ❍ Saturation Biopsy
☐ PINgenius™ reflex for HGPIN
☐ ConfirmMDX™ reflex for: ☐ Negative ☐ HGPIN

❍ Prognostic Panel for Localized Prostate Cancer
☐ PTEN/ERG ☐ oncotypeDX® ☐ Decipher® ☐ Prolaris®
☐ All Gleason grades ☐ 3+3 ☐ 3+4 ☐ 4+3 ☐ ≥8

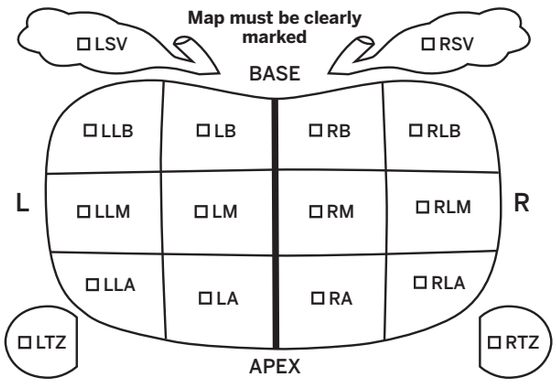
❍ knowerror®
For core with highest grade: ☐ Unilateral ☐ Bilateral

Signature Required† _____

REQUIRED

Total # of **PROSTATE** JARS submitted: ☐

REQUIRED for laboratory accessioning purposes



❍ Other:

TARGETED BIOPSIES WILL BE PUT ON THE FIRST PAGE OF THE PATHOLOGY REPORT.

WE WILL THEN DEFAULT TO OUR STANDARD ORDER UNLESS OTHERWISE SPECIFIED.

In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that are medically necessary for the diagnosis and treatment of patient.

6655 N. MacArthur Blvd., Irving, Texas 75039 / 866.588.3280 / Fax 866.688.3280 / CLIA 45D0975010
15 Crawford St., Suite 100, Needham, MA 02494 / 866.588.3280 / Fax 866.688.3280 / CLIA 22D0957540

† Signature is required to order these tests.

Specimen Labels

10000
Patient Name _____
DOB _____

Affix the appropriate label to the specimen vial you are submitting.
Include patient's first and last name and date of birth on each label.
Each label will tie back to the requisition.

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Left Lateral Base
10000
Patient Name _____
DOB _____

Left Lateral Mid
10000
Patient Name _____
DOB _____

Left Lateral Apex
10000

Spec. _____
10000
Patient Name _____
DOB _____

Left Base
10000
Patient Name _____
DOB _____

Left Mid
10000
Patient Name _____
DOB _____

Left Apex
10000
Patient Name _____
DOB _____

Left Transition Zone
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Right Base
10000
Patient Name _____
DOB _____

Right Mid
10000
Patient Name _____
DOB _____

Right Apex
10000
Patient Name _____
DOB _____

Right Transition Zone
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Right Lateral Base
10000
Patient Name _____
DOB _____

Right Lateral Mid
10000
Patient Name _____
DOB _____

Right Lateral Apex
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

Spec. _____
10000
Patient Name _____
DOB _____

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BILLING INFORMATION — PRIMARY INSURED ☐ **SECONDARY** Please check box and attach copy of front and back of patient's card.			
We file all primary and secondary insurance plans if information is provided. Complete fields below or attach copy of front and back of patient's card.			
Payer ❍ Medicare ❍ Insurance ❍ Patient ❍ Client ❍ Other _____			Patient Status ❍ Non-hosp ❍ Hosp in-patient ❍ Hosp out-patient
Insurance Carrier	Pre-authorization Code	Policy Number/Insured ID Number	Group Number
Claims Address	Claims Phone #		Policy Holder's Name
Policy Holder's Relationship to Patient ❍ Self ❍ Spouse ❍ Dependent		Policy Holder's DOB / /	Policy Holder's Sex ❍ M ❍ F