LINCOLN DIAGNOSTICS LLC.
37 Josephine Street, Staten Island, NY 10314
•Tel: 718-981-5730 •Fax: 718-228-4602
Diagnosis@LincolnLab.us

Specimen #

For Lab Use ONLY

UROLOGIC PATHOLOGY REQUISITION

CLIENT INFORMATION

Requesting Physician _____

PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth *(Required)* _____/_____/_____ | Gender *(Req.)* ☐M ☐F | Date Specimen Collected *(Req.)* _____/_____/_____

Street Address | Apt. #

City | State | Zip

Social Security # | Telephone #

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT AND BACK), OR FILL IN THE NECESSARY INFORMATION BELOW, THANK YOU

☐ **Check here if self-pay** (If checked, please, attach the acknowledgment form)

☐ **Secondary insurance exists.** If checked, please include a photocopy of both carriers and clearly indicate primary and secondary.

Insurance Carrier: | Address | City | State | Zip

Name of Insured *(if different from patient)*: | Insurance ID: | Group #

DOB of Insured _____/_____/_____ | Gender ☐M ☐F | Relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Diagnosis Code(s):

HISTOLOGY

Tests Required. Please check box.

☐ **Prostate Histology Only**

☐ **Prostate Histology with specific instructions** _____

_____

Bladder Histology

☐ **Biopsy Site 1** ☐ **Biopsy Site 3**
☐ **Biopsy Site 2** ☐ **Biopsy Site 4**

☐ **Penile Histology**

☐ **Testicular Histology – Infertility**

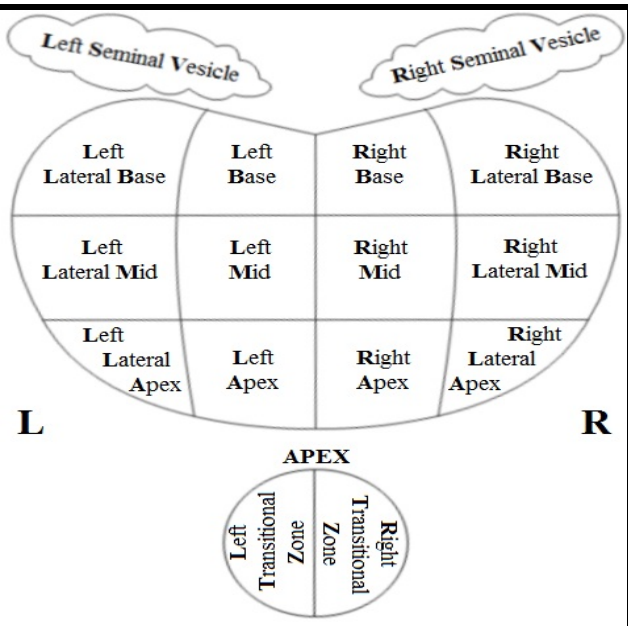
☐ **Testicular Histology – Other**

☐ **Vas deferens**

☐ **Skin, specify site** _____

☐ **Other** _____

_____



Please designate specimen sites: _____

_____

CLINICAL INFORMATION

Last PSA result _____ **ng/ml**

Date _____/_____/_____

DRE: ☐ **Normal** ☐ **Abnormal**

Abnormal findings: _____

_____

Previous biopsy: ☐ **None** ☐ **Benign**
☐ **Inflammation** ☐ **Atypia**
☐ **HPIN** ☐ **Malignant**

☐ **Other** _____

Previous therapy: ☐ **None** ☐ **BCG**
☐ **Hormonal** ☐ **Chemotherapy**
☐ **Radiation** ☐ **Cryo/Surgery**

☐ **TCC History: Dx Date** _____

☐ **Hematuria** ☐ **Dysuria**
☐ **Proteinuria** ☐ **Cystitis**

X _____
Physician's Signature *(required in NY, NJ, MA and PA)* Date

NOTE: SPECIMEN CONTAINERS MUST INCLUDE PATIENT NAME AND BIOPSY SITE