Anatomical & Clinical Pathology
Bio-Path Medical Group
17150 Newhope Street, Suite 117
Fountain Valley, CA 92708
714-433-1330
FAX 714-755-2984

UROLOGY TEST REQUISITION

PATIENT INFORMATION

NAME LAST	FIRST	M.I.	DATE OF BIRTH	SEX M F	SOCIAL SECURITY NUMBER
STREET	APT. NO.		CITY	STATE	ZIP
PHONE ( )			CHART #		

BILLING INFORMATION

- ☐ BILL CLIENT
- ☐ BILL INSURANCE COMPANY (COPY CARD AND ATTACH)
- ☐ BILL PATIENT DIRECTLY
- ☐ BILL PATIENT'S VISA, M/C _____
  Exp. Date _____ Authorized Signature _____

MEDICARE No.

INSURANCE INFORMATION

INSURANCE CARRIER:

I.D. No. | GROUP No.

CLAIMS ADDRESS

CITY | STATE | ZIP

REGULATIONS REQUIRE THAT ALL SPECIMENS BE LABLED WITH PATIENTS NAME AND SPECIMEN SITE

BIOPSY REQUEST

DATE OBTAINED _____ PSA LEVEL _____

SPECIMEN SOURCE

- ☐ URINE
- ☐ URETHA
- ☐ PENIS
- ☐ PROSTATE
- ☐ BLADDER
- ☐ OTHER _____

ICD-9 CODE: _____

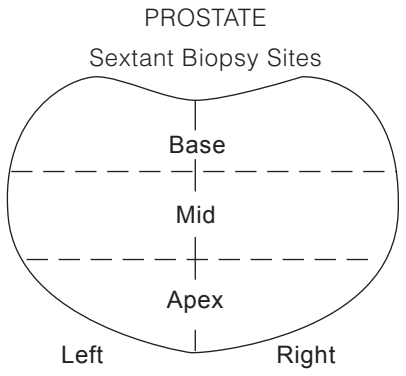
CLINICAL HISTORY

- ☐ CONDYLOMA
- ☐ BPH
- ☐ PROSTATITIS
- ☐ KIDNEY STONES
- ☐ CYSTITIS
- ☐ OTHER _____
- ☐ TUMOR: Type: _____

TUMOR Hx: _____

SPECIMEN SITE(S)

SITE 1	SITE 7
SITE 2	SITE 8
SITE 3	SITE 9
SITE 4	SITE 10
SITE 5	SITE 11
SITE 6	SITE 12



FOR LABORATORY USE

LAB COPY

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