MPA
MORRISTOWN PATHOLOGY ASSOCIATES
MORRISTOWN, NJ • 973-867-7298

DT101

GU PATHOLOGY REQUISITION

PATIENT

NAME: Last / First

STREET / APT #:

CITY / STATE / ZIP:

PHONE #:	DATE OF BIRTH:
SOCIAL SECURITY #:	SEX: ☐ Male ☐ Female

BILLING INFORMATION ATTACH INSURANCE FACE SHEET IF AVAILABLE

INSURANCE - PRIMARY *Please attach copy of insurance card*

CARRIER:	SUBSCRIBER: DOB:	
☐ Commercial ☐ HMO ☐ Medicare ☐ Medicaid	INSURANCE ID #:	GP #:

INSURANCE - SECONDARY

CARRIER:	INSURANCE ID #:

PROCEDURE DATE:

PHYSICIAN

DOCTOR NAME:

PRE-OPERATIVE DX / ICD-10 CODE:

CLINICAL INFO:

CLINICAL INFORMATION

ICD-10 CODES

PSA ________

DRE ☐ Normal ☐ Abnormal

PRIOR BIOPSY ☐ None ☐ Benign ☐ Atypical ☐ PIN ☐ Malignant ☐ Other

PRIOR THERAPY ☐ None ☐ Hormonal ☐ BCG ☐ Radiation ☐ Chemo ☐ Surgery

PROSTATE BIOPSIES

LEFT	Spec#	RIGHT	Spec#
☐ Apex	________	☐ Apex	________
☐ Mid	________	☐ Mid	________
☐ Base	________	☐ Base	________
☐ Lateral Apex	________	☐ Lateral Apex	________
☐ Lateral Mid	________	☐ Lateral Mid	________
☐ Lateral Base	________	☐ Lateral Base	________
☐ Finger Directed	________	☐ Finger Directed	________

BLADDER PATHOLOGY

Histopathology	Spec#		Spec#
☐ Site	________	☐ Site	________
☐ Site	________	☐ Site	________

Urine Cytology
- ☐ Voided Urine
- ☐ Bladder Wash
- ☐ Catheterized Urine
- ☐ Post Cysto Voided

Molecular Studies / Other
- ☐ UroVision™
- ☐ Immunocyt™
- ☐ Stone Analysis

CYSTOSCOPY PERFORMED IN CONJUNCTION WITH UROVYSION REQUEST

___ YES ___ NO

MISCELLANEOUS BIOPSY PATHOLOGY

	Spec#		Spec#
☐ Site	________	☐ Site	________
☐ Site	________	☐ Site	________

Patient Signature: ______________________ Date: ________ Time: ________

Physician Signature: ______________________ UPIN#: ________ Date: ________ Time: ________

NOT PART OF THE PERMANENT RECORD

LAB USE ONLY

MPA4 (10/20)