

UroVysion™ FISH Testing Requisition

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SPECIMEN INFORMATION

Urine Other (specify) _____ Date of collection _____

PATIENT IDENTIFICATION

PATIENT NAME _____ SEX Male Female (circle one)

DATE OF BIRTH _____ ADDRESS #1 _____

SOCIAL SECURITY # _____ ADDRESS #2 _____

MEDICAL RECORD NUMBER _____ PHONE _____

REASON FOR REFERRAL

_____ HEMATURIA (ICD9 599.70) _____ OTHER (SPECIFY)

_____ BLADDER CANCER (ICD9 188.9, 239.4) Diagnostic or recurrence? (circle one)

REFERRING PHYSICIAN

Name _____ Phone _____ Fax _____

Address _____

Results also sent to: _____

REFERRING INSTITUTION

Name _____

BILLING INFORMATION

- Bill:** Referring Institution
 Patient Directly
 Patient Insurance (Please attach insurance information)