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A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Urology Test Requisition Form

Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician to receive additional result report:

Physician's Signature: | Date:

Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City: | State: | Zip:

Assigned Sex at Birth (Required): ☐ Female ☐ Male | Date of Birth (Required): | Patient ID#:

Phone Number:

Race: ☐ Alaska Native or American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ Other race ☐ White ☐ Does not wish to disclose ☐ Not provided

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Gender nonconforming ☐ Transgender male-to-female ☐ Transgender female-to-male ☐ Does not wish to disclose ☐ Not provided

Sexual Orientation: ☐ Bisexual ☐ Straight ☐ Gay or Lesbian ☐ Something else ☐ Does not wish to disclose ☐ Not provided

Billing Information (Please include a copy of the front & back of card.)

Billing Type: ☐ Patient ☐ Insurance ☐ Client | Relation (Required): ☐ Self ☐ Spouse ☐ Dependant

Insured's Name (if not patient):

Insured's SS#: | Insured's DOB:

Primary Insurance Carrier: | Medicare, Medicaid or Policy ID#:

Claims Address:

Employer/Group Name: | Group#:

ICD10 codes (required):

Prostate-related Clinical Information
(Necessary for accurate test interpretation)

Patient History (One selection required)
- ☐ Confirmed PSA ≥ 3.0 ng/ml
- ☐ Confirmed persistent significant rise in PSA
- ☐ Confirmed very suspicious DRE
- ☐ Other (please specify):

Biopsy History:
- ☐ No prior biopsy
- ☐ Yes, negative
- ☐ Yes, positive (4Kscore test will not be performed with a positive biopsy result)

DRE Results:
☐ Nodule ☐ No Nodule ☐ Not performed

Prostate Information

Clinical Stage: ☐ T1c ☐ T2a ☐ T2b ☐ T2c ☐ T3

Last Total PSA: _____ng/mL on __/__/__ Last % Free PSA: _____

PSA Trend: ☐ Increasing ☐ Stable Previous 4Kscore: _____ on ___/___/___

Previous Biopsy: ☐ None ☐ Negative ☐ Atypical ☐ Positive

Digital Rectal Exam: ☐ Suspicious ☐ Non-suspicious

MpMRI: ☐ PIRAD Level _____ ☐ Other (please specify):_____

Treatment: ☐ Prostatectomy ☐ Radiation ☐ Cryotherapy ☐ Chemotherapy ☐ Hormones ☐ TURP ☐ Active Surveillance ☐ None

Prostate Biopsy Information

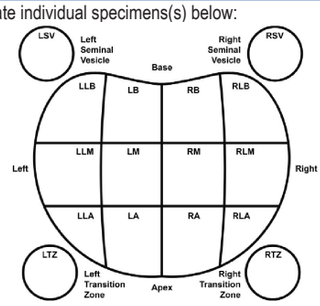
Date Collected (Req.):

Time Collected:

Collector Signature:

No. vials collected:

Please indicate individual specimens(s) below:



With Interpretation:
- ☐ Prostate Biopsy - # of jars: _____
- ☐ Bladder Biopsy - # of jars: _____
- 5620-0 ☐ VAS Deferens/X2
- ☐ Other (please specify):

Bladder Biopsy Information

Date Collected (Req.): | Time Collected: | Collector Signature: | No. vials collected:

Bladder-related Clinical Information (Necessary for accurate test interpretation)

Patient History: Date of Diagnosis: _____ /_____ /_____

☐ Small-cell carcinoma ☐ Adenocarcinoma ☐ Prostate Cancer ☐ Squamous cell carcinoma ☐ Low-grade urothelial carcinoma ☐ High-grade urothelial carcinoma ☐ Carcinoma *in-situ* ☐ Hematuria ☐ Dysuria ☐ Papilloma ☐ Other (please, specify):

Treatment: ☐ None ☐ Resection ☐ Chemotherapy ☐ Radiation ☐ BCG ☐ Other (please specify):

Urologic Specimen Information

Date Collected (Req.): | Specimen Source: ☐ Voided Urine ☐ Catheterization (Urine) ☐ Bladder Washing ☐ Ileal Conduit ☐ Brushing ☐ Ureter

Urine Test Selection

CYTOLOGY - Urine Specimens Only **Required:** ☐ **Fresh Specimen** ☐ **Fixed**

1603 ☐ Urine Cytology

1604 ☐ Comprehensive Urine Pathology (Urine Cytology and UroVysion®)
(If Urine Cytology is atypical or above, reflex to UroVysion®)

Confirmation of Informed Consent and Medical Necessity for Pharmacogenomic Genetic Testing

My signature below acknowledges the patient has been informed about the purpose, limitation and possible risks of genetic testing. The patient has been given the opportunity to ask questions about this consent and seek outside genetic counseling.

If the genetic testing is covered by the patient's health plan and the out-of-pocket expense is less than $150.00, testing will proceed without further delay or additional contact. The patient's signed informed consent is being provided with this requisition. I confirm that this testing is medically necessary for the specified patient and that these results will be used in the medical management and treatment decisions for this patient.

Medical Professional Signature **(Req.)**:_____ Date: _____

Pharmacogenomic Genetic Testing Specimen Information

Date Collected (Req.): | Specimen Source: ☐ Saliva ☐ Whole Blood

Hereditary Genetics Testing - Saliva or Whole Blood

Informed Consent form must accompany specimen

2603 ☐ Hereditary Prostate Cancer Panel (18 genes) by Gene Sequencing and Deletion/Duplication Analysis (ATM, BRCA1, BRCA2, BRIP1, CHEK2, EPCAM, FANCA, HOXB13, MITF, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, TP53)

2604 ☐ Hereditary Renal Cancer Panel (19 genes) by Gene Sequencing and Deletion/Duplication Analysis (BAP1, EPCAM, FH, FLCN, MET, MITF, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL)

1279 ☐ Lynch Syndrome Gene Panel: 5 Genes (EPCAM*, MLH1, MSH2, MSH6, PMS2) by Gene Sequencing with Deletion/Duplication Analysis (*Deletion/Duplication Analysis of Exon8-9 only)

Testing includes sequencing for all genes except EPCAM (del/dup only) and MITF (evaluation of C.952g>A only).

Pharmacogenetics Testing - Saliva or Whole Blood

Informed Consent form must accompany specimen

3707 ☐ **Bladder Incontinence**-Darifenacin, Fesoterodine, Mirabegron, Tamsulosin, Tolterodine (CYP2D6, CYP3A4, CYP3A5)

3708 ☐ **Bladder Cancer**-Cisplatin, Erdafitinib (ABCB1, CYP2C9, CYP3A4, MTHFR, TPMT)

3709 ☐ **Prostate Cancer**-Abiraterone, Apalutamide, Cabazitaxel, Doctaxel, Enzalutamide, Flutamide, Goserelin, Leuprolide, Nilutamide, Prednisone/Prednisolone (ABCB1, CYP1A2, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP2C8, SLCO1B1)

Sexually Transmitted Infections - *UroSwab®*

Common ICD10 codes (required):

Z20.2 ☐ Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission

R30.9 ☐ Painful micturition, unspecified ☐ Other: _____

R36.9 ☐ Urethral discharge, unspecified

191 ☐ Sexually Transmitted Disease (STD) Screen by Real-Time PCR Includes-

- 121 ☐ Leukorrhea Panel (*N. gonorrhoeae**, *C. trachomatis***, *T. vaginalis*)
  - 105 ☐ *Chlamydia trachomatis* (**Reflex to antibiotic resistance by Molecular Analysis)
  - 167 ☐ *Neisseria gonorrhoeae* (*Reflex to antibiotic resistance by Molecular Analysis)
  - 111 ☐ *Trichomonas vaginalis* (Reflex to metronidazole resistance)
  - 129 ☐ *Mycoplasma genitalium* (Reflex to azithromycin & fluoroquinolone resistance by Pyrosequencing)
- 130 ☐ *Mycoplasma hominis*
- 320 ☐ *Ureaplasma urealyticum* (†Reflex to fluoroquinolone resistance by Pyrosequencing)

Urinary Tract Infections - *UroSwab®*

Common ICD10 codes (required):

N39.0 ☐ Urinary tract infection, site not specified

R30.0 ☐ Dysuria

R30.1 ☐ Vesical tenesmus ☐ Other: _____

176 ☐ Urinary Pathogens Antibiotic Resistance* Includes -

- 141 ☐ *Escherichia coli*-AC, C, TS, N, CP, F
- 153 ☐ *Enterococcus faecalis*-A, N, CP, F, D, L
- 154 ☐ *Enterococcus faecium*-A, N, CP, F, D, L
- 728 ☐ *Klebsiella pneumoniae*-AC, C, TS, N, CP, F
- 727 ☐ *Klebsiella oxytoca*-AC, C, TS, N, CP, F
- 146 ☐ *Proteus mirabilis*-AC, C, TS, N, CP, F
- 174 ☐ *Pseudomonas aeruginosa*-CF, PT, I, A, G

*(141, 153, 154, 728, 727, 146 or 174 Req. When panel is ordered and individual tests are not selected, all 7 will be performed & billed)

- 551 ☐ *Candida albicans*
- 559 ☐ *Candida glabrata*
- 730 ☐ *Enterobacter cloacae*
- 127 ☐ Group B Streptococcus (GBS)
- 731 ☐ *Klebsiella aerogenes*
- 362 ☐ *Prevotella* species Group 1 (*P. bivia, P. disiens, P. 1intermedia, P. melaninogenica*)
- 363 ☐ *Prevotella* species Group 2 (*P. corporis, P. albensis*)
- 734 ☐ *Proteus vulgaris*
- 732 ☐ *Providencia* species (*P. stuartii, P. rettgeri*)
- 151 ☐ *Staphylococcus saprophyticus*
- 178 ☐ *Ureaplasma parvum* (Reflex to fluoroquinolone resistance by Pyrosequencing)

Refer to the back for antibiotic abbreviation key.

Antibiotic Abbreviations Key

A = aztreonam **AC**= amoxicillin-clavulanic acid, **AP** = ampicillin, **AZ** = azithromycin, **CC** = ceftriaxone/cefixime, **C** = cephalothin (cephalexin), **CF** = cefepime, **CP** = ciprofloxacin, **CL** = clindamycin, **D** = doxycycline, **F** = fosfomycin, **FL** = fluoroquinolone **G** = gentamicin, **I** = imipenum, **L** = linezolid, **M** = metronidazole **N** = nitrofurantoin, **PT** = piperacillin-tazobactam, **TS** = trimethoprim-sulfamethoxazole.

Medical Necessity Guidelines:

Physicians must only order tests that they have determined are medically necessary for the diagnosis and treatment of a patient. MDL offers individual tests, as well as a limited number of customized panels. MDL provides practitioners with the flexibility to choose appropriate individual tests for each specimen to assure that the convenience of ordering panels does not impede them from ordering tests/panels that are medically necessary. All tests listed in panels may be ordered individually using this test requisition form. If you choose to order a panel, please make certain that each and every test is medically necessary. If you check off a panel as your choice, MDL understands that the physician has determined that all of the component tests are medically necessary, and will perform, report and bill for all such component tests.

** This test can only be performed when the test in parenthesis is positive. All tests performed will be billed.

UroSwab® is registered in the USPTO.

Test by Real-Time PCR unless otherwise specified.

Specimen Collection Platform		TAT*	Stability	Test Additions¥	
Biopsies		3 - 5 days	7 days	30 days to add tests	• Collect specimen and insert into the formalin vial. • The following times must documented on the test requisition form: ° Time of specimen removal from patient ° Time when specimen was placed into formalin
UroSwab®		24 - 72 hours	4 days	14 days to add tests	1. Have patient collect a urine specimen in a collection cup. 2. Dip the sponge swab into collection cup to absorb the urine. 3. Tightly re-secure the cap on the vial.
Urine (for UroVysion® testing)		7 days	24 hours	N/A	• Collect a second morning, clean-catch voided urine. • Minimum volume of 33 mL required, 60 mL desired • Store in refrigerator (4°C) until ready for transport • Pre-freeze cold packs flat to ensure fit in transport box • Do not collect/ship urine specimens on a Saturday
Whole Blood	 Yellow Top Tube (ACD Solution A)	3-5 days	48 hours	30 days to add tests	1. In accordance with the standard operating procedure of your facility, collect blood in two yellow top (ACD solution A) tubes. 2. Allow the tubes to fill properly to ensure the proper blood to anticoagulant ratio. 3. Invert gently several times to mix and prevent clot formation. Do not shake the tubes. Do not centrifuge.
Saliva		5 - 10 days	48 hours	30 days to add tests	• **Vigorously rinse mouth with clean water 5 minutes prior to specimen collection (30 minutes prior is ideal).** • **After rinsing, do not brush teeth, use mouthwash, eat, drink, chew gum or smoke prior to sample collection.** 1. Begin collecting your sample by allowing saliva to pool in your mouth. Then spit into the wide funnel of the tube allowing saliva to collect in the upper chamber of the tube. Fill the tube until the amount of saliva (not bubbles) reaches the fill line as shown. 2. Once filled, unscrew the funnel allowing the saliva to flow into the lower chamber of the tube containing the stabilizing solution. Discard the funnel. 3. Use the blue cap to close the tube tightly. Shake the capped tube for 5 seconds.

** Up to 72 hours with reflex/antiobiotic resistance testing* *¥ Pending QC review for sufficient specimen volume*

Specimen Packaging:

1. Label every vial with a minimum of 2 patient identifiers including the patient's name and date of birth. Be sure the name on the vial is written exactly the same way as on the test requisition form.
2. Place the vial into the Styrofoam/Cardboard container. You can fit up to 3 vials in one container.
3. Place the Styrofoam/Cardboard container into the central pocket of a biohazard bag containing absorbent material.
4. Place a completed test requisition form for each vial in the front pocket of the biohazard bag.
5. Place the biohazard bag into the prepaid Lab pack Envelope that has a preaddressed airbill attached. One envelope will accommodate 6-7 containers. Package as many containers in one Labpack as possible.
6. Be sure to seal the Lab pack by removing the plastic from the top of the adhesive.

Specimen Pick-up:

- If you have a specimen pick-up for a local courier in the NJ, PA, DE, D.C., MD, VA, KS, MO or Phoenix, AZ area, please call (877) 205-0005 no later than 2 hours prior to the closing of your facility.
- If you have a specimen pick-up, please call your sales representative or MDL customer service at 877.269.0090 no later than 2 hours prior to the closing of your facility.

Helpful Hints Checklist

Please review these helpful hints to reduce specimen discrepancies and enhance turnaround time.

Verify Patient Name - did you:

- ✓ attach the correct demographics sheet?
- ✓ write the patient's name on the requisition form?

Patient Name Matches on Vial & Requisition Form- did you:

- ✓ make sure names on vial and requisition form match?
- ✓ list the patients married or maiden name?
- ✓ list a nickname by mistake?

Verify Date of Collection- did you:

- ✓ write the correct year?
- ✓ write the correct month?
- ✓ list the date of birth instead?

Verify Tests- did you:

- ✓ clearly mark each box?
- ✓ order tests appropriate for the specimen type?

No Tests Ordered- did you:

- ✓ mark the boxes for the tests/panels ordered?

Supply Orders:

Easily place supply orders online by visiting our website:

http://www.mdlab.com/physicians/supplies/#

Supply orders may also be placed by contacting our Client Services department toll free 877.269.0090 or by fax 609.570.1050. Supply requests are processed and shipped on a daily basis. Please allow 3 to 5 business days for delivery, depending upon your location.

MDL Contact Information	TOLL FREE	FAX
GBS Hotline *24 hours - 7 days a week* *Group B Strep & HSV results only*	877.MDL.GBS7 877.635.4277	
Quality Control Department *For Technical Assistance*	877.269.0090	609.245.7665
Client Services *General Questions, Results*	877.269.0090	609.570.1050
Client Services *Billing Questions*	877.333.9233	609.245.7683