PENINSULA
HISTOPATHOLOGY LABORATORY, INC.

UROLOGICAL PATHOLOGY
SPECIMEN REQUISITION FORM

PATIENT INFORMATION

PATIENT ID	COMMENTS		
SURGICAL ID			
NAME, LAST	NAME, FIRST	AGE	SEX
STREET		DATE OF BIRTH	
CITY	STATE / ZIP	DATE OF COLLECTION	
PATIENT PHONE NO. ( )	PATIENT CELL NO. ( )	PATIENT EMAIL	
RACE/ETHNICITY			

ACCOUNT

PHYSICIAN

DX CODE:

BILLING INFORMATION

BILL TO:		INSURANCE CARRIER	
INS. ID#	GROUP #	SUBSCRIBER'S NAME	DATE OF BIRTH
INSURANCE ADDRESS	CITY	STATE	ZIP
SECONDARY INSURANCE CARRIER NAME	INS. ID# / GROUP #	SUBSCRIBER'S NAME	DATE OF BIRTH
INSURANCE ADDRESS	CITY	STATE	ZIP

CLINICAL INFORMATION

PAST HISTORY OF

☐ BLADDER CA ☐ RESECTION ☐ CHEMOTHERAPY
☐ RADIATION ☐ BCG ☐ OTHER: _____

SPECIMEN / TEST REQUEST

	Source:	Test Request:
SPECIMEN A	☐ VOIDED ☐ CATHETERIZED ☐ POST-CYSTO VOID ☐ ILEAL CONDUIT ☐ BLADDER WASH ☐ OTHER	☐ ROUTINE HISTOLOGY ☐ CYTOLOGY ☐ URO17
SPECIMEN B	☐ VOIDED ☐ CATHETERIZED ☐ POST-CYSTO VOID ☐ ILEAL CONDUIT ☐ BLADDER WASH ☐ OTHER	☐ ROUTINE HISTOLOGY ☐ CYTOLOGY ☐ URO17
SPECIMEN C	☐ VOIDED ☐ CATHETERIZED ☐ POST-CYSTO VOID ☐ ILEAL CONDUIT ☐ BLADDER WASH ☐ OTHER	☐ ROUTINE HISTOLOGY ☐ CYTOLOGY ☐ URO17