



UROLOGY TEST REQUISITION

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	E-MACH	A TOTAL STATE		PATIENT INF	ORMATION		The state of the state of	
	Last Name		First N	First Name			COLLECTION DATE	
REQUIRED	Date of Birth		[]	[] Male [] Female		COLLECTION TIME	TIME PLACED IN FORMALIN	
	Address					ORDERING PHYSICIAN NAI	ORDERING PHYSICIAN NAME (Last, First) PLEASE PRINT	
R	City			Zip		PHYSICIAN OFF	PHYSICIAN OFFICE INFORMATION	
	Home Number (Work Number)				
BILLING		ATTACH BOTH SIDES OF ALL INSURANCE CARDS						
DIA	GNOSIS	ICD10:	D10:			COPIES TO: NAME / FAX	COPIES TO: NAME / FAX	
						COPIES TO: NAME / FAX		
0						TED, SIGNED BY THE PATIENT	AND ATTACHED	
Specir	nen Information	Collection Date MM / DD ,	/ 4444	Collection Tim		/ PM		
Seminal Vescle Lateral Base Medial Base Base Lateral Mid Medial Mid Medial Mid Medial Apex Medial Apex Apex Apex Apex Apex Apex Apex Apex			A	PROSTATE BIOPSY CLINICAL INFORMATION A B C D				
			Lateral Mid					
			ateral					
			E_					
Mark biopsy location.								
n P		OTHER PATHOLOGY		BLADDE	R BIOPSY		URINE	
□ Vas Deferens R L Both			А			☐ Urine Cytology ☐ Urine Cytology w/ Refle	ex to UroVysion ™	
☐ Testes R L Both ☐ Other Sites:			В	В			☐ UroVysion ™ PLUS (Urine Cytology & UroVysion ™ w/	
			c			correlative interpretation	SPECIMEN TYPE/VOLUME ml	
			D _			UU (voided urine) CU (catheterized urine		
			E			BW (bladder wash)		
1			l l			Urethral wash: R Other:		