LUMEA, Inc.
2889 W Ashton Boulevard STE 300
Lehi, UT 84043
844-960-3658
CLIA 46D2103543
FedEx Pickup: 1-800-463-3339

| LABORATORY USE | |
|---|---|
| Accession # | |
| Date/Time Received | # of Specimens |

# CYTOLOGY REQUISITION FORM

* = Required

## PATIENT AND BILLING INFORMATION

| *Patient Name | *Gender ☐ Male ☐ Female | *Birthdate |
|---|---|---|

*A COPY OF THE PATIENT'S DEMOGRAPHIC AND INSURANCE INFORMATION MUST BE SUBMITTED WITH THE SPECIMENS AND THIS REQUISITION FORM

## ENCOUNTER INFORMATION

| *Physician | *Date of Collection |
|---|---|
| *Clinic | *Medical Assistant |

## *ICD-10 CODE

- ☐ R31.0 Gross hematuria
- ☐ R31.1 Benign essential microscopic hematuria
- ☐ R31.2 Other microscopic hematuria
- ☐ R31.9 Hematuria, unspecified
- ☐ D09.0 Carcinoma in situ of bladder
- ☐ D41.4 Neoplasm of uncertain behavior of bladder
- ☐ C67.9 Malignant neoplasm of bladder, unspecified
- ☐ Z85.51 Personal history of malignant neoplasm of bladder
- ☐ Z80.52 Family history of malignant neoplasm of bladder
- ☐ Other _____

## *CYTOLOGY REQUEST

- ☐ Urine Cytology
- ☐ Urine Cytology w/reflex Bladder FISH - Atypical/Suspicious Cytology
- ☐ Urine Cytology w/bladder FISH - regardless of Cytology result
- ☐ Bladder FISH (only)
- ☐ Other _____

## *SPECIMEN INFORMATION

- ☐ Voided Urine
- ☐ Catherterized Urine
- ☐ Bladder Wash
- ☐ Ileal Conduit
- ☐ Clean Catch
- ☐ Other _____

## PREVIOUS CYTOLOGY

Date: _____

Result:

- ☐ None
- ☐ Benign
- ☐ Atypical
- ☐ Malignant

## PREVIOUS TREATMENT

- ☐ Resection
- ☐ Chemotherapy
- ☐ Radiation
- ☐ BCG
- ☐ Ileal Conduit/Neobladder

## PHYSICIAN AUTHORIZATION

I hereby authorize testing and confirm: 1) that informed consent has been obtained, if required by state law; 2) that this test is medically necessary and the results will be used in the medical manage-ment and treat-ment decisions for the patient; 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to histopathology laboratory service providers, including LUMEA, Inc., and to ancillary healthcare services providers as necessary. I authorize LUMEA and other designated healthcare service providers to release the information on this form, and other information provided by me, necessary to process a claim for this service. I hereby attest that the person listed in the Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein.

| *Signature of Referring Provider (DO, MD, NP, PA) | *Date |
|---|---|