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

PROSTATE BIOPSY REQUISITION FORM

* = Required

PATIENT AND BILLING INFORMATION

*Patient Name	*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 Procedure
*Clinic	*Medical Assistant

PROGNOSTIC INFORMATION - For Partin/Han Predictions and Ancillary Tests

*Clinical Stage (Results of Patient DRE)
- ☐ T1c (No nodules)
- ☐ T2a (<=50% involvement on 1 lobe)
- ☐ T2b (>50% involvement on 1 lobe)
- ☐ T2c (Both lobes involved)

*Last Total PSA: ng/ml

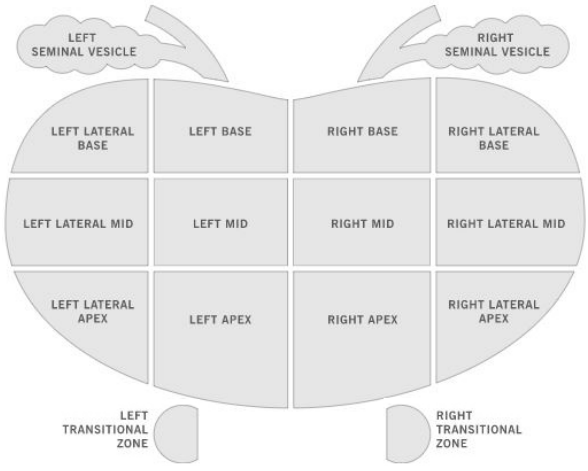
Date of PSA:

*ICD-10 Code
- ☐ R97.2 Elevated PSA
- ☐ N40.2 Nodular Prostate
- ☐ N40.1 Enlarged Prostate
- ☐ D40.0 Neoplasm of Uncertain Behavior of Prostate
- ☐ Other: _____

Previous Biopsy:
- ☐ None
- ☐ Negative
- ☐ Suspicious
- ☐ Positive
- ☐ Hormonal Block

TRADITIONAL SPECIMEN INFORMATION

*Mark an "X" over each site from which specimens are being submitted. If multiple cores are removed, write the amount on the corresponding site.



OUTLIER SPECIMEN INFORMATION

Use white cassettes and write cassette ID below

Location	Cassette ID:
Left Seminal Vesicle	
Right Seminal Vesicle	
Left Transitional Zone	
Right Transitional Zone	

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