LUMEA, Inc.
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FedEx Pickup: 1-800-463-3339

LABORATORY USE	
Accession #	
Date/Time Received	# of Specimens

PROSTATE BIOPSY REQUISITION FORM ROI - BXBOARD

* = 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)	*Last Total PSA: ng/ml	*ICD-10 Code	Previous Biopsy:
☐ T1c (No nodules) ☐ T2a (<=50% involvement on 1 lobe) ☐ T2b (>50% involvement on 1 lobe) ☐ T2c (Both lobes involved)	Date of PSA:	☐ R97.2 Elevated PSA ☐ N40.2 Nodular Prostate ☐ N40.1 Enlarged Prostate ☐ D40.0 Neoplasm of Uncertain Behavior of Prostate ☐ Other: ___________	☐ None ☐ Negative ☐ Suspicious ☐ Positive ☐ Hormonal Block

ADDITIONAL SPECIMEN INFO - For additional cores and lane corrections

CORRECTIONS

L

LEFT SEMINAL VESICLE
LEFT LATERAL BASE
LEFT BASE
LEFT LATERAL MID
LEFT MID
LEFT LATERAL APEX
LEFT APEX
LEFT TRANSITIONAL ZONE

R

RIGHT SEMINAL VESICLE
RIGHT BASE
RIGHT LATERAL BASE
RIGHT MID
RIGHT LATERAL MID
RIGHT APEX
RIGHT LATERAL APEX
RIGHT TRANSITIONAL ZONE

If cores are placed out of order on the BxBoard do not move the tissue. Instead, mark sites above with their corresponding lane #'s.

ROI BxBoards

ROI BxBoard #1: ________________________________

ROI BxBoard #2: ________________________________

ROI BxBoard #3: ________________________________

ROI BxBoard #4: ________________________________

Be sure to label the thumb tab of each used ROI BxBoard (1, 2, 3...) and then write the corresponding ROI site name on the blank space above.

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

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