



LUMEA, Inc.  
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LABORATORY USE	
Accession #	
Date/Time Received	# of Specimens

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

ADDITIONAL SPECIMEN INFO - For additional cores and lane corrections	
<div style="text-align: center;"> <h3>CORRECTIONS</h3> </div> <p style="color: red; font-size: small;">If cores are placed out of order on the BxBoard do not move the tissue. Instead, mark sites above with the lane number where the tissue was placed.</p>	<div style="text-align: center;"> <h3>X1 BxBoard</h3> </div> <p>Lane 1: _____</p> <p>Lane 2: _____</p> <p>Lane 3: _____</p> <p>Lane 4: _____</p> <p>Lane 5: _____</p> <p>Lane 6: _____</p> <p style="color: red; font-size: small; text-align: center;">For each "X" BxBoard, write what was placed in each lane (1-6)</p>

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 management and treatment 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