1 Post, Suite 100, Irvine, CA 92618 | T: (949) 687-1212 | F: (949) 682-7117
CLIA #: 05D2185450 | CA License #: CDF-90000893 | info@promisdx.com

promis DX

Laboratory Test Requisition Form

☐ **Test Ordered: Urinalysis (10SG) with Reflex to Microscopic Exam**

Sample Type: Urine without additives (Refrigerated up to 24 hours)

ID:

☐ **Test Ordered: EarlyTect® Bladder Cancer Detection (EarlyTect® BCD)**

Sample Type: Urine (Collected in EarlyTect® Urine Collection Kit)

ID:

Sample Collection Date and Time: ____________________

I. HEALTHCARE PROFESSIONAL/PROVIDER INFORMATION (Required)

Account #: ____________________ Practice Name: ____________________

Ordering Physician: ____________________ NPI#: ____________________

Address: ____________________ City: __________ State: ______ Zip Code: __________

Email Address: ____________________ Phone number: ____________________ Fax number: ____________________

Select the preferred method for test result deliver: ☐ Provider Portal (Account set-up required) ☐ Fax ☐ Mail

II. PATIENT INFORMATION (Required)

Last name: ____________________ First Name: ____________________ Middle Initial(s): __________

DOB (MM/DD/YYYY) ______/______/__________ Medical Record Number: ____________________

Gender: ☐ Female ☐ Male ☐ Undisclosed Email Address: ____________________

Address: ____

City: ______________ State: ______ Zip Code: __________ Phone number: ____________________ ☐ Mobile

III. PATIENT HISTORY (Required)

Smoking History:

☐ Non-Smoker (less than 100 cigarettes/lifetime) ☐ Ex-Smoker (stopped more than 1 year ago) ☐ Current Smoker

Hematuria History:

☐ No known or recent history of hematuria (within the last 1 year)

☐ Microhematuria, confirmed by dipstick or microscopy

☐ Macrohematuria / Gross hematuria (visible blood in urine)

Macrohematuria most recent event: ☐ Within a week ☐ Within a month ☐ Within 3 months ☐ Within a year

Bladder Cancer History:

Have the patient ever diagnosed with bladder cancer or urothelial carcinoma including UTUC before? ☐ No ☐ Yes

If yes, please specify the name of diagnosis and date: ____________________

Fill out the form fully and send it back with your sample to avoid delays. For help, contact Promis Diagnostics customer service.

For further assistance, contact EarlyTect® BCD or Promis Diagnostics customer service

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ID:

ID:

IV. BILLING INFORMATION (Required)

☐ Private Insurance ☐ Medicare ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

Insurance Information: Attach a copy of the front and back of patient insurance card and fill out form.

Primary insurance carrier: ______________________________Member ID#: __________________Group ID#: ______________

Name of insured: Last: _________________________First: ________________________DOB: ________/________/________

Relationship to insured:
☐ Self ☐ Spouse ☐ Dependent ☐ Other: ____________________

Secondary insurance carrier: ___________________________Member ID#: ___________________Group ID#: ______________

Name of insured: Last: _________________________First: ________________________DOB: ________/________/________

Relationship to insured:
☐ Self ☐ Spouse ☐ Dependent ☐ Other: ____________________

V. PATIENT AUTHORIZATION (Required)

I have read the informed consent document and I give permission to Promis Dx to perform testing as described. I authorize Promis Dx to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/ insurance carrier and its authorized representatives as necessary for reimbursement. I also give permission for my specimen and clinical information to be used in de-identified studies at Promis Dx and for publication of study results, if appropriate, or I have checked the box below to opt out of research. My name or other personal identifying information will not be used in or linked to the results of any studies and publications.

☐ Opt out of research

Print Name: ____________________________________

Patient's Signature: ______________________________

Date: ___________

VI. PHYSICIAN SIGNATURE (Required)

I attest that the patient has signed an informed consent or has had it read to him/her/them, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. My signature certifies that I am a licensed medical professional or his/her/their representative who is authorized to order tests on his/her/their behalf.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Print Name: ____________________________________

Physician's Signature: ____________________________

Date: ___________

VII. ICD-10 (Required)

☐R31.0 - Gross hematuria
☐R31.1 - Benign essential microscopic hematuria
☐R31.2 - Other microscopic hematuria
☐R31.9 - Hematuria, unspecified
☐N30.90 - Cystitis with hematuria
☐N10 - Acute pyelonephritis
☐N13.0 - Hydronephrosis with ureteropelvic junction obstruction
☐N18.9 - Chronic kidney disease, unspecified
☐N30.1 - Interstitial cystitis (chronic)
☐N30.00 - Acute cystitis without hematuria
☐Other: _________________________

☐N39.0 - Urinary tract infection, site not specified
☐N39.41 - Urge incontinence
☐N41.0 - Acute prostatitis
☐N41.1 - Chronic prostatitis
☐O23.00 - Infections of kidney in pregnancy, unspecified trimester
☐O23.10* - Infections of bladder in pregnancy, unspecified trimester
☐O86.20* - Urinary tract infection following delivery, unspecified
☐R10.2 - Pelvic and perineal pain
☐R32 - Unspecified urinary incontinence
☐Z87.440* - Personal history of urinary (tract) infections
*combined with Z16 code

VIII. HEALTHCARE PROFESSIONAL/PROVIDER'S COMMENTS

Fill out the form fully and send it back with your sample to avoid delays. For help, contact Promis Diagnostics customer service.

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