TruCore Pathology
Little Rock, AR 72204
Ph: (501)537-7856 F: (501)410-1166
CLIA# 04D2144056

**Use provided label or ship specimens to:**
**1300 Centerview Dr.**
**Little Rock, AR 72211**
**FedEx Pickup: 1-800-463-3339**

| 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

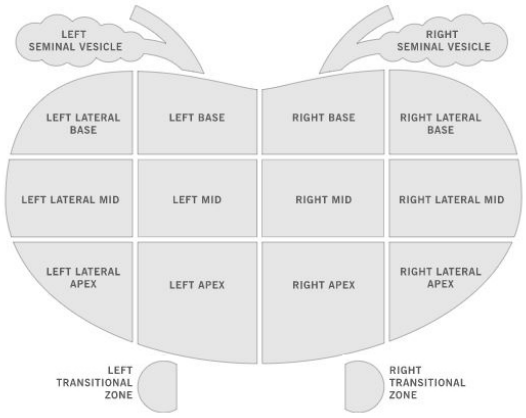
| *Physician (please circle) | *Date of Procedure |
|---|---|
| *Clinic | *Medical Assistant |

## PROGNOSTIC INFORMATION - For Partin/Han Predictions and Ancillary Tests

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

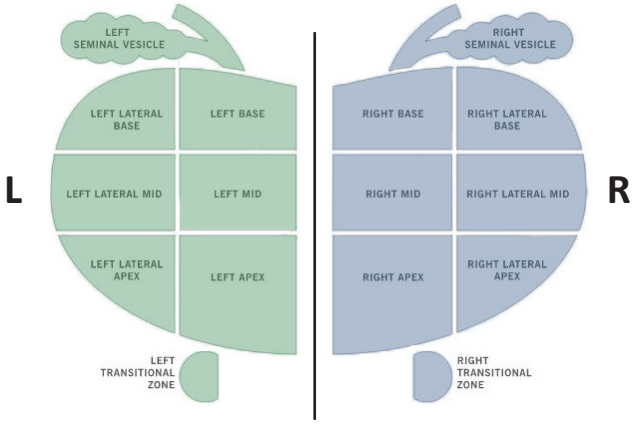
## ADDITIONAL SPECIMEN INFO - For additional cores and lane corrections

### OUTLIER BXBOARD #1




Mark additional cores (ones taken beyond the 12 total placed into the Left & Right BxBoards) on the map with their corresponding lane #'s.

### CORRECTIONS




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

## 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 |
|---|---|
| | |

Kits provided courtesy of: LUMEA