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

EarlyTect® Bladder Cancer Detection Laboratory Test Requisition Form

ID:

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

Sample Type: ☐ Urine (Collected in EarlyTect® Urine Collection Kit) **Sample Collection Date:**_____

I. 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:_____

II. 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 _____

III. 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

☐ Other: _____

IV. HEALTHCARE PROFESSIONAL/PROVIDER INFORMATION (Required)

Last name: _____ First Name: _____ Middle Initial(s): _____

NPI#:_____ Practice Name or Account#: _____

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

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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
Tel: (949) 687-1212 | Fax: (949) 682-7117, E-mail: info@promisdx.com, Monday-Friday, 9 AM - 5 PM

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V. 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

VI. 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:_____ Date: _____

Patient's Signature: _____

VII. 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:_____ Date: _____

Physician's Signature:_____

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