Test Requisition Form

1. Client Information:

Ordering Urologist Name:_____ Hospital/Clinic:_____

Address:_____ Postal Code:_____ Town/Locality:_____ Country:_____

Phone:_____ Fax:_____ Email:_____

2. Molecular Diagnostics: (Please check box)

☐ SelectMDx for Prostate Cancer The urine sample submitted will be analyzed by SelectMDx for Prostate Cancer, a mRNA assay to aid in the decision for biopsy.

3. Patient Information:

Name: (First)_____ (Middle)_____ (Last)_____ Phone:_____

Address:_____ Postal Code:_____ Town/Locality:_____ Country:_____

Medical Record/Patient ID:_____

Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐ (Day – Month – Year)

Date of Last DRE: ☐☐ – ☐☐ – ☐☐☐☐ (Day – Month – Year) Last DRE: ☐ Suspicious for cancer ☐ Not suspicious for cancer

Date of Last PSA: ☐☐ – ☐☐ – ☐☐☐☐ (Day – Month – Year) Last PSA:_____ng/mL

Prostate Volume:_____cc Family history of prostate cancer: ☐ Yes ☐ No

4. Specimen Information:

Collection Date: ☐☐ – ☐☐ – ☐☐☐☐ (Day – Month – Year)

5. Billing Information:

☐ Direct Client Bill - (contract required) ☐ Pre-Payment of test ☐ Credit Card ☐ Patient Self-pay:_____ *Signature*

6. Additional Notes:

_____

_____

7. Authorization:

_____ Date: ☐☐ – ☐☐ – ☐☐☐☐ (Day – Month – Year)

Authorized Signature (*No stamped signatures please*)

Place Patient ID Sticker

Bar Code

MDxHealth

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