

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) Credit Card Patient Self-pay: _____
Signature

6. Additional Notes:

7. Authorization:

 Authorized Signature (No stamped signatures please)

Date: - -
Day Month Year

Place Patient ID Sticker

Bar Code