DAHL-CHASE
PATHOLOGY ASSOCIATES

PROSTATE REQUISITION

Dahl-Chase Pathology Associates
417 State St., Suite 540. Bangor, ME 04401
207-941-8200 / 1-800-660-1626

PLEASE PRINT - COMPLETE ALL AREAS **OR** ATTACH DEMOGRAPHIC SHEET **AND** FILL IN THE SHADED SECTIONS.

Patient Name: (Last, First)			Medicare #:
Date of Birth: _____/_____/_____	Sex: ☐ M ☐ F	Telephone:	Medicaid #:
Social Security:	MR #:		Commercial Ins. Name:
Address: (Mailing)			Commercial Ins. Policy: / Group #:
(City, State, Zip)			Commercial Ins. Address (Street):
Requesting Clinician Name (Last, First):			(City, State, Zip)
Physician Office/Clinic/Hospital Name:			Copy to Clinician Name (Last, First, and office location):
Collection Date & Time: _____/_____/_____ _____:_____	Requisition completed by:		☐ Correlation with previous or concurrent case: _____

PRIORITY:
☐ Routine ☐ Next business day rapid (will call office)
☐ Next day rapid (will call provider on weekends and holidays)
Provider contact # required _____

LOCATION OF COLLECTION:
☐ Day Surgery ☐ OR
☐ Emergency Room ☐ Outpatient / Lab
☐ Endoscopy ☐ Physician office patient
☐ Inpatient Floor ☐ Radiology/Ultrasound

CLINICAL INFORMATION (REQUIRED FOR ALL TESTS-include patient diagnosis & history)

Clinical Date:

PSA_____ng/ml % Free PSA
Digital Rectal Exam
☐ Suspicious ☐ Non Suspicious
Hypoechoic Lesion
☐ Suspicious ☐ Non Suspicous
Previous Biopsy
☐ None ☐ Negative
☐ Suspicious ☐ Positive
Other

Therapy:

☐ TURP ☐ Prostatectomy
☐ Hormone Therapy ☐ Cryosurgery
☐ LH/RH Agonist ☐ Radiation
☐ 5 Alpha Reductase Inhibitor ☐ Chemotherapy

Comments:

Location of Specimens

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

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