

Cancer Screening & Detection

Test Requisition Form

Please Fax to 877-764-7628

6555 Sanger Rd Suite 260, Orlando FL 32827

CLIA ID#: 10D2192649

CAP ID#: 8832145

CDPH ID#: CDS-90005103

Medical Director: Anthony Magliocco MD, FCAP

PROTEAN
BIODIAGNOSTICS

Customer Service: 1 (754) 242 9682
support@proteanbiodx.com

Patient Information

Name (Last, First, MI)

DOB (MM/DD/YYYY)

☐ Female (XX) ☐ Male (XY)
☐ Other (X___)

Phone (primary)

Street Address

City

State

Postal Code

Country

MRN (Medical Record Number)

Ordering Physician Information

Physician Name / NPI #

Fax

Office / Practice / Institution

Physician's Email

Street Address

City

State

Postal Code

Country

Office Contact Name

Contact Phone

Contact Email

Insurance Billing Information

Primary Insurance

Policy #

Group #

Primary Policy Holder

DOB

Secondary Insurance

Policy #

Group #

Secondary Policy Holder

DOB

Patient Billing Information

Patient Name

Patient Email

Patient Phone Number

Patient Mailing Address

City

State

Postal Code

Country

ICD-10 CODE: _____

Clinical History

- ☐ Cancer (specify type): _____
- ☐ DRE Date: _____
- ☐ Previous PSA: _____
- ☐ Other Clinical Data & Comments: _____

Collection Method

- ☐ Voided Urine ☐ Ureteral Washing ☐ RT ☐ LT
- ☐ Catheterized ☐ Urine Pelvic Washing ☐ RT ☐ LT
- ☐ Bladder Washing

Testing Options

Urinalysis for Bladder Cancer

- ☐ Cytopathology Review ☐ URO17 ☐ PDL1 (SP142) ☐ PDL1(SP263) ☐ HER2

- ☐ Complete Analysis (Includes All the Above Tests)

Certificate of Medical Necessity, Consent, Test Authorization, and Physician Signature

My signature is a Certificate of Medical Necessity by the treating physician that this testing has been explained and is authorized for the care of the patient and that consent has been obtained for Protean BioDiagnostics to release results as part of reimbursement, for follow up information to be obtained, and for the data to be de-identified and disclosed for quality assurance and research. Protean BioDiagnostics customer service may be contacted for any discounts if insurance does not fully cover and with any questions. Unless otherwise indicated, it is acknowledged that Protean BioDiagnostics may direct the testing selected based on the requisition and approach listed on the Protean BioDiagnostics website, according to the pathology reports, and status or quantity of the specimen received.

Ordering Physician Signature

Printed Name

_____/_____/_____
Date (MM/DD/YYYY)

Place Barcode Label Here

Submission Checklist

- | | | |
|---|---|--|
| <input type="checkbox"/> Signed Requisition (this form) | <input type="checkbox"/> Insurance Sheet | <input type="checkbox"/> Specimens |
| <input type="checkbox"/> Driver's License or Other ID | <input type="checkbox"/> Front and Back of Insurance Card | <input type="checkbox"/> Previous Pathology Report (If Applicable) |

Notes or Instructions:

Specimen Requirements

Urine

Handling & Shipping Instructions

TBD

Shipping Information

Protean BioDiagnostics
6555 Sanger Road Suite 260,
Orlando FL 32827

Email: support@proteanbiodx.com

Phone: 1 (754) 242 9682