



# Highlands Pathology Consultants, P.C.

## TEST ADD-ON REQUEST FORM Cytology Department

**Please fax back to: 423-224-5349**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Specimen type: \_\_\_\_\_ Date: \_\_\_\_\_

HPC specimen #: \_\_\_\_\_

Requesting physician: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Test(s) to be ordered / added:

**UroVysion Bladder Cancer by FISH**

**Diagnosis Code(s):**

\_\_\_\_\_

\_\_\_\_\_  
**Ordering Physician or Designee Signature  
(REQUIRED)**

\_\_\_\_\_  
**Date**

For HPC Internal Use Only

Date/Time request received: \_\_\_\_\_

Request processed by: \_\_\_\_\_

**Highlands Pathology Consultants  
130 West Ravine Road  
Kingsport, TN 37660  
423-224-5789  
Fax: 423-224-5349**