Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

MEDICAL AND TRANSPLANT KIDNEY BIOPSY REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name ______ First ______ MI ______

Address ______ Birth Date ______ Sex ☐ M ☐ F

City ______ SS # ______

State ______ Zip ______ Home Phone ______

Hospital/Physician Office Patient ID # ______ Accession # ______

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: ______/______/______

WORKERS COMP: ☐ Yes ☐ No DOI: ______

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

SECONDARY: ☐ No ☐ Yes (if Yes, please attach) **ABN:** ☐ Yes ☐ No

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. ______ 2. ______ 3. ______

CLINICAL INFORMATION

Clinical Diagnosis/History: ______

Nephrotoxic Medications: ______

Duration of Kidney Disease: ______

Hypertension ☐ Yes ☐ No Duration: ______

Diabetes ☐ Yes ☐ No Duration: ______

Creatinine ______ mg/dl BUN ______ mg/dl Serum Albumin ______ g/dl

Proteinuria: ______ g/24 h -OR- dipstick proteinuria *(circle one)* 0 1+ 2+ 3+ 4+

Urine Sediment ______ RBC/hpf ______ WBC/hpf RBC Casts? + –

Serologies (please circle):

ANA	+	–	Hepatitis B SAg	+	–
Anti-ds-DNA	+	–	Hepatitis C	+	–
C3	Low	Normal	HIV	+	–
C4	Low	Normal	ASO	+	–
CH50	Low	Normal	RF	+	–
C-ANCA	+	–	Cryoglobulins	+	–
P-ANCA	+	–	Monoclonal Protein	Yes	No
Anti-GBM	+	–	If yes, type ______		

CLIENT INFORMATION

REFERRING PHYSICIAN CONTACT

Physician Name ______

Physician Signature ______

Physician NPI# ______

☐ Call Results to phone number: (______) ______

☐ Fax report to: (______) ______

Physician Email ______

SPECIMEN INFORMATION

Please indicate number of tubes, vials, slides, tissue blocks provided

Collection Date: ______/______/______ Time: ______

☐ Native Kidney ☐ Left ☐ Right

☐ Transplant Kidney

Specimen Type(s): (Check all that apply)

☐ Fresh Tissue (Saline Moistened Gauze)

☐ Formalin Fixed (Light Microscopy) Vial

☐ Glutaraldehyde (Electron Microscopy) Vial

☐ Michels Solution (Immunofluorescence) Vial

☐ Paraffin Block

☐ Slides

☐ Other ______

*CPT codes available online at clevelandcliniclabs.com © 2022 Cleveland Clinic Laboratories 6/2022

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