

<p>PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>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.</p> <p>INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>WORKERS COMP: <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (Ohio only) <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <p>CLINICAL INFORMATION</p> <p>Clinical Diagnosis/History: _____</p> <hr/> <p>Nephrotoxic Medications: _____</p> <p>Duration of Kidney Disease: _____</p> <p>Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No Duration: _____</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Duration: _____</p> <p>Creatinine _____ mg/dl BUN _____ mg/dl Serum Albumin _____ g/dl</p> <p>Proteinuria: _____ g/24 h -OR- dipstick proteinuria (circle one) 0 1+ 2+ 3+ 4+</p> <p>Urine Sediment _____ RBC/hpf _____ WBC/hpf RBC Casts? + -</p> <p>Serologies (please circle):</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">ANA</td> <td style="width:33%;">+ -</td> <td style="width:33%;">Hepatitis B SAg</td> <td style="width:33%;">+ -</td> </tr> <tr> <td>Anti-ds-DNA</td> <td>+ -</td> <td>Hepatitis C</td> <td>+ -</td> </tr> <tr> <td>C3</td> <td>Low Normal</td> <td>HIV</td> <td>+ -</td> </tr> <tr> <td>C4</td> <td>Low Normal</td> <td>ASO</td> <td>+ -</td> </tr> <tr> <td>CH50</td> <td>Low Normal</td> <td>RF</td> <td>+ -</td> </tr> <tr> <td>C-ANCA</td> <td>+ -</td> <td>Cryoglobulins</td> <td>+ -</td> </tr> <tr> <td>P-ANCA</td> <td>+ -</td> <td>Monoclonal Protein</td> <td>Yes No</td> </tr> <tr> <td>Anti-GBM</td> <td>+ -</td> <td>If yes, type _____</td> <td></td> </tr> </table>	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 _____		<p style="text-align: center;">CLIENT INFORMATION</p> <hr/> <p>REFERRING PHYSICIAN CONTACT</p> <p>Physician Name _____</p> <hr/> <p>Physician Signature _____</p> <hr/> <p>Physician NPI# _____</p> <p><input type="checkbox"/> Call critical results to phone number: (_____) _____</p> <hr/> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p>Physician Email _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Please indicate number of tubes, vials, slides, tissue blocks provided</p> <p>Collection Date: ____/____/____ Time: _____</p> <p><input type="checkbox"/> Native Kidney <input type="checkbox"/> Left <input type="checkbox"/> Right</p> <p><input type="checkbox"/> Transplant Kidney</p> <p>Specimen Type(s): (Check all that apply)</p> <p><input type="checkbox"/> Fresh Tissue (Saline Moistened Gauze)</p> <p><input type="checkbox"/> Formalin Fixed (Light Microscopy) Vial</p> <p><input type="checkbox"/> Glutaraldehyde (Electron Microscopy) Vial</p> <p><input type="checkbox"/> Michels Solution (Immunofluorescence) Vial</p> <p><input type="checkbox"/> Paraffin Block</p> <p><input type="checkbox"/> Slides</p> <p><input type="checkbox"/> Other _____</p>
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