

# MEDICAL AND TRANSPLANT KIDNEY BIOPSY REQUISITION

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PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)	CLIENT INFORMATION																																																
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<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><b>INSURANCE BILLING INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>WORKERS COMP:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p><b>PRIMARY:</b> <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> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%; border-bottom: 1px solid black;">Subscriber Last Name</td> <td style="width:30%; border-bottom: 1px solid black;">First</td> <td style="width:40%; border-bottom: 1px solid black;">MI</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Beneficiary / Member #</td> <td colspan="2" style="border-bottom: 1px solid black;">Group #</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Claims Address</td> <td style="border-bottom: 1px solid black;">City</td> <td style="border-bottom: 1px solid black;">State</td> </tr> <tr> <td></td> <td style="border-bottom: 1px solid black;">Zip</td> <td></td> </tr> </table> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) <b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Subscriber Last Name	First	MI	Beneficiary / Member #	Group #		Claims Address	City	State		Zip		<p><b>REFERRING PHYSICIAN CONTACT</b></p> <p style="border-bottom: 1px solid black;">Physician Name</p> <p style="border-bottom: 1px solid black;">Physician Email</p> <p style="border-bottom: 1px solid black;">Physician NPI#</p> <p><input type="checkbox"/> Call critical results to phone number: (____) _____</p> <p><input type="checkbox"/> Fax report to: (____) _____</p>																																				
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<p><b>CLINICAL INFORMATION</b></p> <p>Clinical Diagnosis/History: _____</p> <p>_____</p> <p>_____</p> <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><b>Serologies (please circle):</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">ANA</td> <td style="width:10%;">+</td> <td style="width:10%;">-</td> <td style="width:30%;">Hepatitis B SAg</td> <td style="width:10%;">+</td> <td style="width:10%;">-</td> </tr> <tr> <td>Anti-ds-DNA</td> <td>+</td> <td>-</td> <td>Hepatitis C</td> <td>+</td> <td>-</td> </tr> <tr> <td>C3</td> <td>Low</td> <td>Normal</td> <td>HIV</td> <td>+</td> <td>-</td> </tr> <tr> <td>C4</td> <td>Low</td> <td>Normal</td> <td>ASO</td> <td>+</td> <td>-</td> </tr> <tr> <td>CH50</td> <td>Low</td> <td>Normal</td> <td>RF</td> <td>+</td> <td>-</td> </tr> <tr> <td>C-ANCA</td> <td>+</td> <td>-</td> <td>Cryoglobulins</td> <td>+</td> <td>-</td> </tr> <tr> <td>P-ANCA</td> <td>+</td> <td>-</td> <td>Monoclonal Protein</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Anti-GBM</td> <td>+</td> <td>-</td> <td>If yes, type _____</td> <td></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><b>SPECIMEN INFORMATION</b></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"/> Blocks: quantity _____</p> <p><input type="checkbox"/> Stained slides: quantity _____</p> <p><input type="checkbox"/> Unstained/Unbaked Slides: quantity _____ (to preserve the ability to perform molecular testing, if indicated)</p> <p><input type="checkbox"/> Other _____</p>
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