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: _____/_____/_____

ABN: ☐ Yes ☐ No **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)

DIAGNOSIS CODE (REQUIRED) ICD-9 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 _____		
			DSA	+	–

For Renal Allografts: Transplant Date ____/_____/_____ BK Viremia + – _____ copies/ml

☐ LRD ☐ LURD ☐ Deceased Donor

CLIENT INFORMATION

REFERRING PHYSICIAN CONTACT

Physician Name

Physician Signature

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

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 _____

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