WISCONSIN DIAGNOSTIC LABORATORIES
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AFFIXED LABEL

RENAL PATHOLOGY REQUEST FORM

REQUIRED INFORMATION FROM REQUESTING AREA

Patient Last Name | First | M.I.

Street Address

City | State | ZIP

Phone Number

Patient ID/MRN | Sex | Birthdate

Collection Date/Time: | Collector's Initials

BILL TO: ☐ Client / Clinic ☐ Patient ☐ Medicare ☐ Medicaid ☐ Insurance

Insurance CO. Name and Address or Attach Copy of Both Sides of Insurance Card

Insurance ID # | Medicare # ☐ Primary ☐ Secondary

Insurance / Group # | Medicaid #

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Name of Insured | ICD-10 | ICD-10

Employer | ICD-10 | ICD-10

Advance Beneficiary Notice (ABN) Obtained: ☐ Yes ☐ No

ORDERING PROVIDER INFORMATION

Referring Institution / Nephrology Practice Name

Nephrologist / Ordering Physician

Phone Number | Fax Number

Send Additional Copy or Report To:

BRIEF CLINICAL HISTORY AND REASON FOR BIOPSY (You may also attach recent nephrology note and lab results):

☐ Native Kidney ☐ Transplant Kidney

PAST MEDICAL HISTORY

☐ Diabetes ☐ Obesity ☐ Hypertension ☐ Monoclonal Gammopathy ☐ Smoking ☐ Other: _____

Family History of kidney disease? ☐ Yes ☐ No Additional Information: _____

LABS

Current S. Creatinine_____
Baseline S. Creatinine_____
24 HR Urine Protein_____
Urine Prot Cr Ratio_____
Hematuria_____
Urine Sediment_____

SEROLOGY

ANA_____
anti-dsDNA_____
ANCA_____
MPO/PR3_____
anti-GBM_____
C3_____
C4_____
PLA2R_____
Hep. B_____
Hep. C_____
HIV_____
Cryo_____
SPEP/UPEP_____
Free LC Ratio_____
Other:_____

Date of Transplant:_____
Donor: ☐ Living ☐ Deceased
KDPI:_____

Native Kidney Disease:_____
Viral Studies:_____

DSA_____
CsA/Tacrolimus_____

WHITE COPY - LAB YELLOW COPY - CLIENT