Washington University Physicians®

PATHOLOGY: Renal Biopsy (Transplant Kidneys)

Ship samples to:

Washington University Pathology Services
Clinical Support Office
425 S. Euclid Ave. | MSC 8024-14-04 | St. Louis MO 63110
Tel: (314) 747-1100 | Fax: (314) 362-4080

Office use only
Date/Time Received:
Accession Number:
Technician Initial
Received:
Formalin (LM) Michel's (IF) Glutaraldehyde (EM)

This requisition has two pages, please complete it completely and accurately.

PATIENT IDENTIFICATION

Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex: ☐Male: ☐Female:	
Medical Record # (if applicable):		
Address:		
City:	State:	Zip:

PHYSICIAN ORDER TEST (NPI required)

Name Last:	First:	MI:
NPI:	Email:	
Phone:	Fax:	
Pager:		
Address:		
City:	State:	Zip:

SPECIMEN INFORMATION

Date of biopsy:
Date of transplant: Donor ☐ Cadaveric ☐ Living-Related ☐ Living-Unrelated ☐
Original cause of renal failure:

REASON FOR TESTING (required, failure to include diagnosis may delay testing)

Diagnosis:
ICD10 Code(s):

THERAPY

Medication	Dose/Level	Medication	Dose/Level
Prednisone		Azathioprine	
MMF/Cellcept/Myfortic		Cytoxan	
FK506/Tacrolimus		Campath (Alemtuzumab)	
Cyclosporine		Thymoglobulin	
Sirolimus/Rapamycin		Other:	

HISTORY

Diabetes ☐Yes ☐No
Hypertension ☐Yes ☐No
Infection ☐Yes ☐No
Blood Pressure:

LABORATORY DATA

Urine Levels

Proteinuria ☐Yes ☐No gm/24h or ☐0 ☐1+ ☐2+ ☐3+ ☐4+
Hematuria ☐Yes ☐No
RBC Casts ☐Yes ☐No WBC Casts ☐Yes ☐No
Polyoma (BK) Virus: Other Infectious Agents:

Serum Levels

Creatinine (present peak): Creatinine (baseline, last 3 months):
Donor Specific Antibodies ☐Yes ☐No
HBV ☐Yes ☐No ☐Unknown HCV ☐Yes ☐No ☐Unknown HIV ☐Yes ☐No ☐Unknown
CMV: Polyoma (BK) Virus:
Bacteria: Fungi: Other Infections Agents:

ADDITIONAL INFORMATION:

Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity
I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature: Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Insurance Co. Phone:	
Relationship to patient:	Plan Name:	
	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	