

**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 both pages to ensure testing.**

PATIENT IDENTIFICATION				PHYSICIAN Ordering TEST <i>(NPI required)</i>			
Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office Visit				Name:			
Name Last:		First:	MI:	Institution:			
DOB (mm/dd/yyyy):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	NPI:		Email:		
Medical Record # (if applicable):				Address:			
Address:				City:		State:	Zip:
City:		State:	Zip:	Phone:		Fax:	
Ethnicity (select all that apply)				Alternative Contact Information:			
<input type="checkbox"/> African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian/NW European		Phone:		Email:	
<input type="checkbox"/> E Indian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Jewish-Ashkenazi	<input type="checkbox"/> Jewish-Sephardic	Notes:			
<input type="checkbox"/> Mediterranean	<input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Other				

**SPECIMEN INFORMATION** *(required, failure to include diagnosis may delay testing)*

Date of biopsy:

History and Clinical Diagnosis:

ICD10 Code(s):

*\*For transplant patients, please use Transplant Kidney Requisition*

THERAPY		HISTORY			
Medication	Dose/Level				
Antibiotics:		Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihypertensives:		Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	SLE	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressants:		Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> 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

UPEP:

**Serum Levels**

Creatinine:                      BUN:                      Creatinine Clearance:

Albumin:                      Complement C3:                      Complement C4:

Glucose:                      HgbA1c:                      ANA:

Anti-DNA:                      Anti-GBM:                      SPEP:

ANCA:                      MPO ANCA     Yes     No                      PR3 ANCA     Yes     No

HBV                       Yes     No     Unknown                      HCV                       Yes     No     Unknown                      HIV                       Yes     No     Unknown

**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):
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**BILLING INFORMATION  
(CHECK ONE)**
 **Bill Patient/Insurance-Complete Section A**
 **Bill Submitting Institution-Complete Section B**
**SECTION A-PATIENT/INSURANCE BILLING INFORMATION**

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. 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](mailto: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 Unit Authorized:	

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

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

**SECTION B-INSTITUTIONAL BILLING**

Institution Name:				
Contact Name:			PO Number (if applicable):	
Email:				
Accounts Payable Billing Address:				
City:		State:		ZIP:
Phone:		Fax:		