

**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**

|                                           |                                                           |                                                |                                           |
|-------------------------------------------|-----------------------------------------------------------|------------------------------------------------|-------------------------------------------|
| Patient Status:                           | <input type="checkbox"/> Inpatient                        | <input type="checkbox"/> Outpatient            | <input type="checkbox"/> Office Visit     |
| Name Last: last name page 1               | First: first page 1                                       | MI:                                            |                                           |
| DOB (mm/dd/yyyy):                         | Sex:                                                      | <input type="checkbox"/> Male                  | <input type="checkbox"/> Female           |
| Medical Record # (if applicable):         |                                                           |                                                |                                           |
| Address:                                  |                                                           |                                                |                                           |
| City:                                     | State:                                                    | Zip:                                           |                                           |
| Ethnicity (select all that apply)         |                                                           |                                                |                                           |
| <input type="checkbox"/> African American | <input type="checkbox"/> Asian                            | <input type="checkbox"/> Caucasian/NW European |                                           |
| <input type="checkbox"/> E Indian         | <input type="checkbox"/> Hispanic                         | <input type="checkbox"/> Jewish-Ashkenazi      | <input type="checkbox"/> Jewish-Sephardic |
| <input type="checkbox"/> Mediterranean    | <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Other                 |                                           |

**PHYSICIAN Ordering TEST (NPI required)**

|                                  |                    |              |
|----------------------------------|--------------------|--------------|
| Name:                            |                    |              |
| Institution:                     |                    |              |
| NPI:                             | Email:             |              |
| Address:                         |                    |              |
| City: doc city                   | State: doc state   | Zip: doc zip |
| Phone: doc phone                 | Fax:               |              |
| Alternative Contact Information: |                    |              |
| Phone:                           | Email: email doc 1 |              |
| Notes:                           |                    |              |

**SPECIMEN INFORMATION**

|                                  |                                                                                                                                                     |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of biopsy:                  |                                                                                                                                                     |
| Date of transplant:              | Donor <input type="checkbox"/> Cadaveric <input type="checkbox"/> Living-Related <input type="checkbox"/> Living-Unrelated <input type="checkbox"/> |
| Original cause of renal failure: |                                                                                                                                                     |

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

|                |  |
|----------------|--|
| Diagnosis:     |  |
| ICD10 Code(s): |  |

**THERAPY**
**HISTORY**

| Medication            | Dose/Level | Medication            | Dose/Level |                                                                       |
|-----------------------|------------|-----------------------|------------|-----------------------------------------------------------------------|
| Prednisone            |            | Azathioprine          |            | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| MMF/Cellcept/Myfortic |            | Cytoxan               |            | Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No |
| FK506/Tacrolimus      |            | Campath (Alemtuzumab) |            | Infection <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Cyclosporine          |            | Thymoglobulin         |            | Blood Pressure:                                                       |
| Sirolimus/Rapamycin   |            | Other:                |            |                                                                       |

**LABORATORY DATA**

|                                                                                               |                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Urine Levels</b>                                                                           |                                                                                                                                                      |
| Proteinuria <input type="checkbox"/> Yes <input type="checkbox"/> No                          | gm/24h or <input type="checkbox"/> 0 <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ |
| Hematuria <input type="checkbox"/> Yes <input type="checkbox"/> No                            |                                                                                                                                                      |
| RBC Casts <input type="checkbox"/> Yes <input type="checkbox"/> No                            | WBC Casts <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                   |
| Polyoma (BK) Virus:                                                                           | Other Infectious Agents:                                                                                                                             |
| <b>Serum Levels</b>                                                                           |                                                                                                                                                      |
| Creatinine (present peak):                                                                    | Creatinine (baseline, last 3 months):                                                                                                                |
| Donor Specific Antibodies <input type="checkbox"/> Yes <input type="checkbox"/> No            |                                                                                                                                                      |
| HBV <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | HCV <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                                                        |
| CMV:                                                                                          | HIV <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                                                        |
| Bacteria:                                                                                     | Polyoma (BK) Virus:                                                                                                                                  |
| 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): |
|------------|-------------|-----|-------------------|

**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:                       |      |