Washington University Physicians
Washington University School of Medicine in St. Louis

PATHOLOGY: Renal Biopsy (Transplant Kidneys)

Ship samples to:

Washington University Diagnostic Laboratory Services
Attn: AMP Core Lab
509 S. Euclid Ave., 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.

PHYSICIAN ORDERING TEST *(NPI required)*			**PATIENT IDENTIFICATION**		
Name:			Name Last:	First:	MI:
NPI:	Email:		DOB (mm/dd/yyyy):	Gender: ○ Male ○ Female	
Phone:	Fax:		Medical Record # (if applicable):		
Pager:					
Address:			Address:		
City:	State:	Zip:	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				**HISTORY**
Medication	**Dose/Level**	**Medication**	**Dose/Level**	
Prednisone		Azathioprine		Diabetes ○ Yes ○ No
MMF/Cellcept/Myfortic		Cytoxan		Hypertension ○ Yes ○ No
FK506/Tacrolimus		Campath (Alemtuzumab)		Infection ○ Yes ○ No
Cyclosporine		Thymoglobulin		Blood Pressure:
Sirolimus/Rapamycin		Other:		

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:

PATHOLOGY: Renal Biopsy (Transplant Kidneys)

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 e-mail 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:	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#:

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 e-mail at path-billing@email.wustl.edu.

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

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