Affix patient sticker here

Arkana Laboratories

Renal Biopsy Requisition Form

Surgical Number: _____

☐ Inpatient ☐ Outpatient

Admission Date: _____

Collection Date: _____

Biopsy Tissue Type:

☐ Native ☐ Transplant

Materials Submitted For:

☐ Renal Biopsy Evaluation
(Light, Immunofluorescence, and Electron Microscopy)

☐ Other: _____

Specimen(s) Identification: _____

_____

Patient Name: _____ Date of Birth (MMDDYYYY): _____

Social Security #: _____ Gender: ☐ M ☐ F Race: _____

Address: _____ Phone #: _____

Payor: ☐ Patient ☐ Referring Facility ☐ Other: _____

Please attach a copy of insurance card and authorization or face sheet.

Ordering Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Send additional copy of report to: _____

_____

Indication of Biopsy: _____

Past Medical History: ☐ Diabetes ☐ Hypertension ☐ MGUS ☐ Gout ☐ Smoking ☐ Obesity ☐ Other: _____

Brief Clinical History: _____

_____

_____

_____

Family history of kidney disease: ☐ Yes ☐ No

Transplant:

CsA/Tacrolimus _____ Native Kidney Disease _____

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

Labs:

S. Creatinine _____ mg/dl 24 Hour Urine Protein _____ Hgb A1C _____ Hematuria _____

GFR _____ Urine Prot:Cr Ratio _____ Serum Albumin _____ Hgb _____

Serology:

ANA _____	PR3 _____	PLA2R _____	Cryo _____	SSA/SSB _____
anti-dsDNA_____	anti-GBM _____	Hep. B _____	RF _____	SCL-70 _____
ANCA_____	C3 _____	Hep. C _____	SPEP _____	Other: _____
MPO _____	C4 _____	HIV _____	Free LC Ratio _____	Other: _____

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