Renal Biopsy Requisition Form

Arkana Laboratories

Affix patient sticker here

Surgical Number: _____ ☐ Inpatient ☐ Outpatient

Biopsy Tissue Type: ☐ Native ☐ Transplant

Patient pre-biopsy diagnosis: _____

Materials submitted for: ☐ Light Microscopy ☐ Immunofluorescence ☐ Electron microscopy ☐ Other: _____

Specimen(s) identification: _____

_____

Patient Information:

Patient Name: _____ Social Security #: _____ Gender: M F

Date of Birth (MMDDYYYY): _____ Phone #: _____ Marital Status: ☐ Married ☐ Single ☐ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Name: _____ Social Security #: _____ Date of Birth (MMDDYYYY): _____

Referring Physician:

Nephrologist: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Send additional copy of report to: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Brief clinical history: *attach additional sheets as needed* _____

_____

_____

Third-Party Billing Information: Complete or attach a copy of insurance card and authorization

Insured/Responsible Party: _____ Date of Birth (MMDDYYYY): _____ Gender: M F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Member ID #: _____ ☐ Medicare ☐ Medicaid ☐ HMO ☐ PPO ☐ Other

Policy #: _____ Group #: _____

Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone #: _____

Employer Name: _____ Employer Phone #: _____

Referral Authorization/Precertification #: _____

Print Name: _____ Signature: _____ Date: _____

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