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PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST)   (FIRST)   (M.I.)

ADDRESS | APT#

CITY | STATE | ZIP

(AREA CODE) PHONE | BIRTH DATE | SEX

PATIENT S.S. # | PATIENT I.D.#

BILL TO: ☐ **Account**   ☐ **Patient (Self Pay)**   ☐ **Medicare**   ☐ **Medicaid**
☐ **Insurance**   ∗**Please submit a copy of ID card (front and back)**

INSURANCE COMPANY NAME (attach card) | EMPLOYER NAME

NAME OF INSURED | POLICY / MEMBER ID # | GROUP #

RELATIONSHIP TO INSURED: ☐ SELF   ☐ SPOUSE   ☐ DEPENDENT

SUBMITTING NEPHROLOGIST:_____

PHONE:_____ PAGER:_____

FAX:_____ MOBILE:_____

SUBMITTING PATHOLOGIST: _____

PHONE:_____ FAX:_____

Referring Physician: _____ UPIN: _____ NPI: _____

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

DATE COLLECTED

Send Duplicate Report to:
Name: _____
Address: _____
City/State/Zip: _____

PHYSICIAN ACKNOWLEDGEMENT (Required)
*Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. **Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.***

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE	DIAGNOSIS CODE	DIAGNOSIS CODE

Physician's Signature: _____   **Date Ordered:** _____

RENAL PATHOLOGY REQUISITION

Test(s) Requested (all are required for accurate interpretation of a native biopsy):
☐ Light Microscopy   ☐ Immunofluorescence   ☐ Electron MicroScopy

Specimen Type:
☐ Native Kidney Biopsy
☐ Renal Transplant Biopsy
  Date of Transplant: _____
  Original Disease: _____
  Immunosuppressive Therapy:
  ☐ Prednisone   ☐ CellCept
  ☐ Cyclosporine   ☐ Imuran
  ☐ Prograf   ☐ Rapamune
  ☐ Other: _____

Indication(s) for Biopsy:
☐ Acute Renal Failure
☐ Chronic Kidney Disease
☐ Hematuria
☐ Proteinuria
☐ Hypertension
☐ Diabetes Mellitus
☐ Systemic Lupus Erythematosus (SLE)
☐ Other:_____

Laboratory Test Results (please include most recent data):

Serum Creatinine (mg/dl)_____
Creatinine Clearance (ml/min)_____
Urinary Protein (g/24 hr)_____
Serum Albumin (g/dl) _____
Serum IFE _____
Urine IFE _____

ANA _____
Anti-dsDNA _____
C3 (mg/dl) _____
C4 (mg/dl) _____
Hepatitis C _____
Hepatitis B _____

P-ANCA (MPO) _____
C-ANCA (PR3) _____
Anti-GBM _____
Kidney Size:_____
  Right (cm) _____
  Left (cm) _____

Urinalysis / Urine Microscopy:
☐ Protein   ☐ Blood   ☐ Dysmorphic RBCs   ☐ RBC Casts   ☐ Bacteria   ☐ WBCs

Other Pertinent Historical, Clinical and Laboratory Data:

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Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.