



Patient Legal Name (Last, First MI)	Date/Time
Gender (at Birth) M F	DOB
Ethnicity	SSN / MRN
Address	Telephone Number
City, State, Zip	Diagnosis
Print Physician's Name (F, MI, L)	ICD-10 Diagnosis Codes:
Physicians Signature	<input type="checkbox"/> BILL FACILITY <input type="checkbox"/> BILL PATIENT OR INSURANCE <input type="checkbox"/> SPLIT BILL: TC TO FACILITY & PC TO INSURANCE (Medicare, Medicaid, Tricare)

Client:

RENAL BIOPSY REQUISITION

<input type="checkbox"/> Native Kidney	<input type="checkbox"/> Allograft/Transplant Date:
<input type="checkbox"/> AKI Yes No	
<input type="checkbox"/> Hematuria Yes No	
<input type="checkbox"/> CKD Stage I II III IV V	
<input type="checkbox"/> Nephritic Yes No	
<input type="checkbox"/> Nephrotic Yes No	
<input type="checkbox"/> Proteinuria Yes No	
<input type="checkbox"/> Rash Yes No	
<input type="checkbox"/> Tobacco Yes No	

Clinical History:

Hypertension:

Diabetes:

Autoimmune Disease:

Creatinine / eGFR:

Laboratory Pathologists:

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