



Patient Legal Name (Last, First MI)
DOB
() ROUTINE
Date/Time of Collection
Patient SSN #
Ethnicity
MR#/Alternate Pt ID
() PHONE
Phone:
Address
Phone
() STAT
Fax:
City, State, Zip
M F
Physicians Signature
Order Date
Print Physicians Name (F, MI, L)
NOTE: For split and patient bill: Attach Face Sheet & Insurance Card
Client:
Referring Physician/Nephrologist:
ICD-10 Diagnosis Codes:
Telephone:
Final Report Fax:

KIDNEY BIOPSY REQUISITION

Fax requisition & face sheet to IU Health Pathology Lab, before specimen is shipped. Fax #: 317.491.6419, "Attn: Renal Biopsy"

Check here if biopsy specimen is CRITICAL and/or shipped on Friday for Saturday delivery.

SPECIMEN TYPE
CLINICAL HISTORY & BIOPSY INDICATION:
Native Kidney
Allograft/Transplant Date:
AKI Yes No
CKD Stage? I II III IV V
Hematuria Yes No
Nephritic Yes No
Nephrotic Yes No
Proteinuria Yes No
Rash Yes No
Tobacco Yes No

Laboratory Data

Chemistry
Urinalysis
Serology
Creatinine, Serum
Creatinine Clearance
BUN
Albumin
Glucose
HgB A1C
Hemoglobin
Platelets
Protein
RBC
WBC
Glucose
Urine P:C Ratio
24-hr. Protein
Complements
ASO
ANA
ANCA
Hep A/B/C
Rheumatoid factor
HIV
dsDNA
GBM
PLA2R
Cryoglobulins

Laboratory Pathologists:

Carrie Phillips MD 317.491.6494 cphill3@iu.edu Shunhua Guo MD 317.491.6491 sguo@iuhealth.org