



**Oregon Health & Science University
Hospitals and Clinics**
Department of Pathology L471
Portland, OR 97239
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DEPARTMENT OF PATHOLOGY

Request for Renal Biopsy Consultation

Page 1 of 1

DATE _____

PATIENT NAME _____

AGE _____ SEX _____

SOCIAL SECURITY NO. _____

DATE OF SERVICE _____

ACCESSION NO. _____
(OHSU Lab Use)

REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION *REQUIRED*

Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____
Requesting Physician _____ UPIN/NPI _____ Phone _____
Who should get a copy of the report? _____

KIDNEY BIOPSY CLINICAL DATA

Clinical History including Indication for Biopsy and and approximate dates of onset and previous episodes: _____

ICD-9 Diagnosis Code(s) _____

Clinical Data:

BUN, Creatinine, GFR: _____
Proteinuria: _____
Urine Sediment: _____
Blood Pressure: _____
Renal Imaging: _____
Serologies: _____
SPEP/UPEP: _____
Other: _____

Transplant Information:

Transplant date and source of the allograft: _____
Original cause of renal failure: _____
History of rejections: _____

Current Medications: _____

Clinical Impression: _____

Additional Information: use the reverse side

BILLING INFORMATION *REQUIRED* PLEASE FILL OUT THE FOLLOWING OR ATTACH THE INFORMATION

Select One Billing Method:
 Referring Lab/Physician (Client) Patient Third Party-Primary Third Party-Secondary Medicaid/OHP Medicare

Preauthorization Number _____ Insurance Company _____
Policy Number _____ Group Number _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

Responsible Party (Guarantor):

Name _____ Social Security No. _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____