(IF YOU ARE COMPLETING THIS FROM BY HAND, USE BLACK OR BLUE INK)

MEDICAL RECORD #	UAB MEDICINE RENAL PATHOLOGY REQUISITION 1802 6th Ave S. NP3501 (205) 934-4442	CLINIC LOCATION	COLLECTION DATE

NAME (LAST) (FIRST) (MIDDLE)	SUBMITTING PHYSICIAN NAME	PHYSICIAN'S # or NPI

AGE	SEX	DATE OF BIRTH	SUBMITTING PHYSICIAN CONTACT PHONE

SOCIAL SECURITY NUMBER		FOR UAB INPATIENT KEYPLATE,
Insurance Company		FOR OUTPATIENT -ATTACH A PRINT OUT OF
Responsible Party		THE PATIENT'S INSURANCE INFORMATION
Guarantors Name		
Policy Number		
Bill to	☐ Hospital ☐ Patient	
IRB/Policy #		LAB USE ONLY PLACE ACCESSION LABEL HERE
DUPLICATE REPORTS TO - Physician or Facility Name/ FAX #		

CLINICAL INFORMATION

Clinical History:

Laboratory Studies:
Creatinine _____
Urinary Protein (24-hr or protein/creatine ratio)_____
Complements_____
Serologic data (ANA, ANCA etc.) _____

SOURCE(S) OF SPECIMEN(S) SUBMITTED:

☐ Routine Diagnostic Biopsy (Light, IF, EM)
☐ Transplant Biopsy
☐ Other _____

For additional specimens use 2nd sheet

Authorized Signature

SP19990801