LSU Health Shreveport, LA – Pathology Outreach Services

Client Contact Information

Institution/Office: _____

Contact Person: _____

Phone:_____ Fax: _____

Nephrologist: _____

Phone:_____ Cell: _____

Email: _____

Pathologist: _____

Phone: _____ Fax: _____

Email: _____

Patient Information

Specimen ID: _____

Patient Name: _____

DOB: _____ Sex: M___F ____

Race: _____ COVID 19Exposure: Y___N ____

Please note, provided cell phone number and email address will only be used by LSU pathologist in efforts to contact the submitting Nephrologist/Physician. A cell phone number or direct number to the Physician is a necessity for communication between LSU Pathologist and submitting Physician. Not doing so may delay communication of important information pertaining to the case.

Please note, not providing clinical information may delay the result of the biopsy
Please print and attach any additional pertinent clinical history

Clinical History

- ☐ Acute/Rapid Renal Failure
- ☐ Chronic Renal Failure
- ☐ Hypertension
- ☐ Proteinuria
- ☐ Lupus
- ☐ HIV
- ☐ Elevated Creatinine
- ☐ AKI (Acute Kidney Injury)
- ☐ Hematuria
- ☐ ESRD (End-Stage Renal Disease
- ☐ Nephrotic Syndrome
- ☐ Family Hx of Kidney Failure or Disease
- ☐ CKG (Chronic Kidney Disease)
- ☐ ANCA (Antineutrophil Cytoplasmic Antibodies

Any additional information or labs should be printed to accompany the specimen
**NOT PROVIDING CLINICAL HISTORY COULD DELAY THE RESULT OF YOUR SPECIMEN

Specimen Information

Collection Date:_____ Collection Time:_____ Date Recieved:_____ Time Received: _____

Please indicate services required

Native Kidney		Transplant Kidney	
___ Light Microscopy	___Electron Microscopy	___Light Microscopy	___Electron Microscopy
___ Immunofluorescenc	___Electron Microscopy (only)	___Immunofluorescenc	___C4D

Billing Method

___ **Bill Sending Institution/Practice** *Note: The sending institution will be responsible for all billed charges to non-contracted third-party payers, self-pay patients, non-LA/TX Medicaid and Medicare Technical Components.*

Please provide the hospital address and contact person. _____

_____

_____

___ **Medicare/Medicaid** *(We are currently able to accept Medicaid patients only from LA, TX, MS & AR. The sending institution of other states will be responsible for the billed charges.)*

Patient Medicare#: _____ Patient Medicaid#: _____ State: _____

___ **Bill Insurance** ***(Complete information below, or attach front and back copy of insurance card. If more than one company, please indicate which is primary.)***

Insurance Company #1 or
Medicare Supplement:_____ Phone: _____

Address: _____

Policy#: _____ Group#: _____

Subscriber Name: _____ Relation to Patient: _____

Insurance Company #2: _____ Phone: _____

Address: _____

Policy#: _____ Group#: _____

Subscriber Name: _____ Relation to Patient: _____

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Renal Biopsy Specimen/Requisition Instructions

Introduction

The complete and accurate diagnosis of renal biopsies requires evaluation by three modalities: light microscopy, immunofluorescence and electron microscopy. The specimens must be correctly handled according to the instructions provided for physicians and hospitals.

Specimen Handling/Requisition Instructions

Prefilled fixative vials, shipping containers and preprinted prepaid air bills are supplied at no charge by contacting our pathology outreach customer service personnel. **Please call 318-675-8475 (primary number) or 318-675-5976 (alternate number) for ordering supplies or any questions concerning reports.**

1. Immediately after retrieving the biopsy core(s), place one portion of tissue into each of three vials as indicated below:
   a. **Purple Dot Vial** – Michel's – expiration date on vial – for immunofluorescence
   b. **Green Dot Vial** – Formalin – no expiration date – for light microscopy
   c. **Clear Top Vial** – Glutaraldehyde – expiration date on vial – for electron microscopy
2. Complete all requested information on reverse side of this requisition form. Extra information for clinical history and/or insurance may be attached to requisition for customer convenience.
3. Please provide name, phone number and fax number of nephrologist and pathologist to receive a copy of the report.

Reports and Returned Materials

1. Confirmation of specimen receipt, including name and phone number of LSUHSC-Shreveport Renal Pathologist performing renal consultation, will be faxed to sending institution upon specimen arrival.
2. LSUHSC-Shreveport Renal Pathologist will phone results directly to nephrologist.
3. Final reports are faxed upon completion of services.
4. Hard-copy report sent via mail to requesting nephrologist and pathology department.

Billing

Please contact the LSU Health Shreveport Pathology Outreach Services Business Office for current pricing or other billing questions/arrangements at 318-675-5869 (Pathology Business Office). Please note the following:

1. We do not charge for tests not performed due to inadequate sampling.
2. We can bill insurance companies or hospital/practice directly.
3. We are currently able to accept **Medicaid** patients only from LA and TX. The sending institution will be responsible for all billed charges to non-contracted third-party payers, self-pay patients, non-LA/TX Medicaid and Medicare Technical Components. Please complete contact information on front of requisition.

Thank you for your business.