Form Instructions | Print | Save | Reset Form

Atrium Health Wake Forest Baptist Medical Center
Medical Center Boulevard Winston-Salem, NC 27157
(336) 716-2628 (Anatomic Pathology)
(336) 806-9627 (Pathologist On-Call Pager)
(336) 716-7595 (Fax)
http://www.wakehealth.edu/specialty/p/Pathology

Client:	Clinic/Group Name:	
	Address:	
	City, State, ZIP:	
	Fax:	Phone:
	Contact:	Email:

Renal Pathology Request Form

Form must be completed in order to provide pathology services. Incomplete information will delay processing.

PATIENT INFORMATION

Name: *Last Name*	*First Name*	*Middle*	*Mother's First Name*	Soc. Sec. No. (*last 4 digits*):
Marital Status:	Race:	Sex: ☐ Male ☐ Female		Date of birth:
Address:	City:		State:	ZIP:
Phone:	Employer:		Employer Phone:	

BILLING AND INSURANCE INFORMATION

Bill To: *Check box(es) & provide details below. Copies of front AND back of insurance card(s) is acceptable substitute.*	**Primary Insurance:** ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*	
	Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*	
	☐ **Bill Client**	
Complete for all insurers:	**Subscriber Name:**	**Relationship to patient:**
	Policy/ID Number:	
Medicare Information:	Hospital insurance effective date:	Medical insurance effective date:
Medicaid Information:	Carolina Access Number:	Valid from: / To:
	State issued if NOT North Carolina:	
All other insurance information:	Insurance Company:	Phone:
	Address for Claims:	Plan Number:
	City/State/ZIP:	Effective Date:

PHYSICIAN INFORMATION

Ordering Physician (*please print*):		PCP Name:
Signature:	Phone:	Fax:
	Fax:	☐ Fax copy of report to Primary Care Provider

SPECIMEN INFORMATION (*complete additional form(s) if needed*)

URGENT, please call results to:		**Attention:**	
Collection date:	Collection time:	Diagnosis Code/Verbiage:	
Clinical Summary & Diagnosis:			
Hypertension history:	# of years:	# of anti-hypertension medications:	Blood pressure:

Lab Results:	Urinalysis: ☐ Hematuria ☐ Proteinuria ☐ Pyuria ☐ RBC Casts			
	Urine Tests: Pr/Cr:	24-hour Protein:	Creatinine Clearance:	
	Serum Tests: Creatinine:	Albumin:	Cholesterol:	
	ANA:	Anti-ds DNA:	Anti-GBM:	
	ANCA:	HIV:	ASO:	
	Serum C3:	Other:		

Pertinent clinical information, clinical description, additional comments:

FOR PATHOLOGY USE ONLY

Materials received: ☐ Slide(s), Qty: ☐ Block(s), Qty:		Date received:
WFBMC MRN:	HAR #:	CSN #:
WFBMC Case ID:	Initials:	

ORDERS