Arkana Laboratories

Clinical Data Sheet

Affix patient sticker here

Ordering Physician: X _____

Signature authorization for pathology services.

Patient Name: _____ Age: _____ Gender: ☐ M ☐ F Race: _____

Biopsy Type: ☐ Native ☐ Transplant (Please circle) LRD LURD CadTx Ped Donor Extended Donor

Relevant History and Data: _____

_____

_____

Appropriate Clinical Syndrome: **Time Frame:**

☐ Nephrotic Syndrome ..... _____

☐ Acute Nephritic Syndrome ..... _____

☐ Acute Renal Failure ..... _____

☐ Rapidly Progressive Glomerulonephritis ..... _____

☐ Isolated Hematuria (Please circle) Micro / Macro ..... _____

☐ Isolated Proteinuria ..... _____

☐ Chronic Renal Failure ..... _____

☐ Other _____ ..... _____

Labs:

S. Creatinine _____ mg/dl

24 Hr. Urine Protein _____

Hgb A1C _____

GFR _____

CsA / Tacrolimus _____

ESR _____

Serologies:

ANA _____	antiGBM _____	Hep. B _____	Cryo _____	C3 _____
RF _____	cANCA _____	Hep. C _____	HIV _____	C4 _____
ant-ds DNA _____	pANCA _____	SPEP / UPEP _____	ASO _____	CH50 _____

Other: _____

_____

10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com
arkanalabs.com

Arkana Laboratories

Patient Information Sheet

Affix patient sticker here

Patient Information:

☐ Inpatient ☐ Outpatient

Patient Name: _____ Social Security #: _____ Gender: ☐ M ☐ F

Date of Birth (MMDDYYYY): _____ Phone #: _____ Marital Status: ☐ Married ☐ Single ☐ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Phone #: _____ Work Status: ☐ Full-Time ☐ Part-Time ☐ Disabled ☐ Retired

Spouse Name: _____ Social Security #: _____ Date of Birth (MMDDYYYY): _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referring Physician:

Nephrologist: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Physician: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Medical Reason for Referral: _____

Specimen Description: _____ Specimen Source: _____

Insurance Information:

Primary Insurance: _____ Policy #: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insured/Responsible Party: _____ Social Security #: _____ Effective Date (MMDDYYYY): _____

Secondary Insurance: _____ Policy #: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____ Social Security #: _____ Effective Date: (MMDDYYYY) _____

Group Name: _____ Group #: _____ Effective Date: (MMDDYYYY) _____

Medicare #: _____ Effective Date: (MMDDYYYY): _____

Medicaid #: _____ Effective Date: (MMDDYYYY) From: _____ To: _____

10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com
arkanalabs.com

KIDNEY BIOPSY: PRE-PROCDURE REOUIREMENTS/INSTRUCTIONS

01. Referral Order to be filled and faxed to DVC (order document available in the DRG web site/DVC window).

02. From Nephrology Office — most recent H&P or Nephrology Progress Note, Medication List and the completed Biopsy Clinical Data Document of the ARKANA PATHOLOGY LAB.

03. Proof of Medical Insurance (a copy needs to be enclosed in the biopsy specimen box)

04. Latest outpatient lab results (definitely done within 1 to 2 weeks prior to the biopsy/preferably within 1-week duration): CBC, PT, INR, aPTT and UA with or w/o Urine Culture

05. Stop Anti-Platelet Agents (Aspirin/NSAIDs, Plavix, Brilinta, Effient, etc.) x 7 days

06. Stop Anticoagulant – Warfarin (Coumadin) x 4 days

07. Stop NOAC Anticoagulants (Eliquis, Xarelto, Pradaxa, etc.) x 3 days

08. Continue to take all other medications especially the Anti-HTN medications on the day of the biopsy

09. NPO for at least 4 hrs. prior to the procedure

10. Can take ½ dose of the AM Insulin.

11. Patient needs to bring all home medications while coming for the biopsy including Insulin.

12. Patient can also bring packed food while coming for the biopsy.

13. Need a driver — especially while going home after the biopsy.

14. Patient should not have any fever, chills, rigor or any form of infection for at least 48-hrs before the biopsy (unless cleared by the treating/primary nephrologist).

Dallas **Vascular** Center

1222 N. Bishop Ave.. Ste. 500. Dallas. TX 75208 PH: 214-943-1687 FAX: 214-943-9373

****This form is an official request for treatment and serves as a Physician's order**

Kidney Biopsy Referral/Appointment Request

Patient Name:	DOB:
Patient Current Phone:	
Referring Physician:	PHONE:
Physician Signature:	
Nurse Name:	PHONE:
Nurse Signature:	Date:

NOTE: For the following, please check one or more as appropriate:

KIDNEY REQUESTED
[ ] Left
[ ] Right
[ ] Bilateral
[ ] Ultrasound/Doppler

BIOPSY TYPE
[ ] Native Kidney Biopsy
[ ] Transplant Kidney Biopsy

INDICATIONS
[ ]Proteinuria
[ ]Hematuria
  [ ] Micro
  [ ] Macro
[ ] CKD-Unknown Cause
[ ] AKI-Unknown Cause
[ ] Nephrotic Syndrome
[ ] Acute Nephritis Syndrome
[ ] RPGN

+++

IMPORTANT REMINDERS

Please FAX a copy of the following to DVC along with this referral form:

- Face Sheet
- Medication List
- Most Recent H & P
- Most Recent Insurance Information

Please give the patient his/her copy of the **PATIENT APPOINTMENT INSTRUCTIONS** provided by DVC.