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: _____

_____

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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: _____

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