

TEST REQUISITION FORM

To avoid delays complete the entire form

ACCOUNT INFORMATION		PATIENT INFORMATION		
CLINIC NAME	PREDICT AIN ACCOUNT #	PATIENT NAME (LAST, FIRST, INITIAL)		
STREET ADDRESS		PATIENT ID # / MEDICAL RECORD #	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE BIRTH DATE (MM/DD/YYYY)	
CITY	STATE	ZIP	STREET ADDRESS	
PHONE NUMBER	FAX NUMBER	CITY	STATE	ZIP
OFFICE CONTACT		DAYTIME PHONE NUMBER		EMAIL ADDRESS
EMAIL ADDRESS		RACE AND ETHNICITY		
		<input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN OR <input type="checkbox"/> OTHER PACIFIC ISLANDER		
PATIENT CLINICAL INFORMATION				
PROVIDE MOST RECENT VALUES				
Serum creatinine (mg/dl) _____				
Blood urea nitrogen (mg/dl) _____				
Urine dipstick specific gravity _____				
Urine dipstick protein _____				
DIAGNOSIS INFORMATION		BILLING INFORMATION (Choose one option and provide the necessary information)		
ICD-10 CODES ARE REQUIRED				
Patient has been diagnosed with any autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Insurance A legible copy of both sides of insurance cards. Indicate which is primary. Testing may be delayed if not received with the sample.		
ICD-10 Code/s _____		<input type="checkbox"/> Self-Pay Patient will be contacted once sample is received to complete this process and set up payment or payment plan.		
Patient has been diagnosed with Chronic Kidney Disease (CKD) <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Client Client Name: Client Contact:		
ICD-10 Code/s _____		<input type="checkbox"/> Other Third Party Pay Source: Contact Information:		
Other Conditions _____				
ICD-10 Code/s _____				
TEST REQUESTED				
<input type="checkbox"/> PredictAIN - is a quantitative electrochemiluminescence immunoassay using the Meso Sector S 600 instrument for measurement of Tumor Necrosis Factor-alpha, interleukin-9, and CXCL-9 human urine combined with clinical data, using an artificial intelligence-derived algorithm to produce a composite probability score. It is indicated for use as an aid to further assess the probability of acute interstitial nephritis (AIN) in patients with unexplained loss of kidney function.				
AUTHORIZED SIGNATURE				
Physician Name _____ NPI Number _____ Email Address _____				
I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer.				
Physician's Signature _____ Date _____				
SPECIMEN INFORMATION				
DATE SAMPLE WAS TAKEN _____ TIME SAMPLE WAS TAKEN _____				
_____ <input type="checkbox"/> AM <input type="checkbox"/> PM _____				