IMMUCOR | DX
Reference Laboratory kSORT
CLIA# 23D1054909 CAP#7195469

Place Label Here

1-800-363-5915
Mon—Fri 8a-5p EST
301 Michigan Street NE Suite #580
Grand Rapids, MI 49503
www.Immucor.com/DX
ImmucorDX@Immucor.com

kSORT TEST REQUISITION

PATIENT INFORMATION AND ACKNOWLEDGEMENT

Last name: _____ First name: _____ DOB: ____ / ____ / _____

Sex: _____ MRN: _____ Street address: _____

City: _____ State: _____ Zip: _____

The performance characteristics of this Laboratory Developed Test (LDT) were validated by Immucor DX Laboratories. The U.S. Food and Drug Administration (FDA) has not approved this test; however, FDA approval is currently not required for clinical use of this test. Immucor DX is authorized under Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity testing. The results are not intended to be used as the sole means for clinical diagnosis or patient management decisions. My signature below constitutes my acknowledgement that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. The results of my testing are confidential and will only be released to the ordering healthcare provider. Release of results to other medical professionals or directly to me (the patient) must be requested by me in writing. My sample may be stored indefinitely to be used for test validation, education, or research after personal identifiers are removed. I may request disposal of my sample following completion of the test requested above by contacting the laboratory at 800-363-5915.

Patient's Signature: _____ Date: _____/_____/_____

TEST MENU

☒ **kSORT (kidney SOLID ORGAN RESPONSE TEST)**

PATIENT CLINICAL INFORMATION

LABORATORY RESULTS: Creatinine: _____ Date: _____ *If Applicable:* Cystatin C: _____ Date: _____	Biopsy: □ NO □ YES DATE :_____ For Cause: □ YES □ NO Results/Findings: _____ _____ _____ _____
Graft Dysfunction: □ YES □ NO	Peak cPRA:
DSA Present □ NO □ YES	HIGHEST MFI VALUE :_____

PATIENT CLINICAL INFORMATION (On 1st Sample Post Transplant Only)

Date of Transplant:	**INFECTION**	**CURRENT**	**HISTORIC**
No. of Previous Transplants:	CMV	□	□
Underlying Disease Etiology:	EBV	□	□
	BK	□	□
DRUG THERAPY: □ Steroids □ Tacrolimus □ MMF □ Belatacept □ Cyclosporine □ Induction _____	HIV	□	□
	Hepatitis:____	□	□
	Other:	□	□

Multi Organ Transplant (Y/N):
□ Kidney/Pancreas □ Kidney/Liver □ Other _____

CV RISK FACTORS □ Hypertension □ Hyperlipidemia □ Diabetes Mellitus

Race:
□ Caucasian □ African American □ Asian □ Hispanic □ Other_____

DONOR INFORMATION (On 1st Sample Post Transplant)

Donor Type: □ LD □ DD (KDPI)_____

Donor Race:
□ Caucasian □ African American □ Asian □ Hispanic □ Other_____

Donor Age:_____ Donor Gender: _____	ABO Compatible (Y/N):

Infectious Disease Status:
□ CMV □ EBV □ BK □ HIV □ Hepatitis ____ □ Other:_____

SAMPLE COLLECTION (To Be Completed by Specimen Collector)

Date Collected:	Time Collected:
# of Tubes:	(Only Paxgene Tubes are Acceptable)
Collected By (Full Name):	
Collection Site: ☐ Same as Ordering Practice (or complete below)	
Site Name:	
Address:	
City:	
State:	Zip:
If Contracted Draw Site Complete Below:	
Account #:	
Account Name:	

BILLING INFORMATION

☒ Client Billing	Immucor DX Account #_____

PROVIDER INFORMATION AND ACKNOWLEDGEMENT

Ordering Provider:		
NPI#:		
Submitting Client:		
Tel:	Fax:	
Address:		
City:	State:	Zip:
Copy to Provider:		
NPI#:		
Tel:	Fax:	

I confirm that the person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. The patient has given consent for testing to be performed and for their sample to be stored indefinitely to be used for test validation, education, or research after personal identifiers are removed. I acknowledge that any results provided by Immucor DX are confidential and agree that I shall not disclose any such results to any unauthorized person or entity. I understand that the ordering institution is financially responsible for any client bill fees invoiced by Immucor.

Provider's Signature: _____ Date: _____/_____/_____

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