



Renal Biopsy Requisition Form

Surgical Number: _____

Inpatient Outpatient

Admission Date: _____

Collection Date: _____

Biopsy Tissue Type:

Native Transplant

Materials Submitted For:

Renal Biopsy Evaluation
(Light, Immunofluorescence, and Electron Microscopy)

Other: _____

Specimen(s) Identification: _____

Patient Name: _____ Date of Birth (MMDDYYYY): _____

Social Security #: _____ Gender: M F Race: _____

Address: _____ Phone #: _____

Payor: Patient Other: _____

Referring Facility: _____

Please attach a copy of insurance card and authorization or face sheet.

Ordering Physician: _____

Phone #: _____ Fax #: _____

Send additional copy of report to: _____

Indication of Biopsy: _____

Past Medical History: Diabetes Hypertension MGUS Gout Smoking Obesity Other: _____

Brief Clinical History: _____

Family history of kidney disease: Yes No

Transplant:

CsA/Tacrolimus _____ Native Kidney Disease _____

DSA _____ Date of Transplant _____ Donor: Living Deceased

Labs:

S. Creatinine _____ mg/dl 24 Hour Urine Protein _____ Hgb A1C _____ Hematuria _____

GFR _____ Urine Prot:Cr Ratio _____ Serum Albumin _____ Hgb _____

Serology:

ANA _____ PR3 _____ PLA2R _____ Cryo _____ SSA/SSB _____

anti-dsDNA _____ anti-GBM _____ Hep. B _____ RF _____ SCL-70 _____

ANCA _____ C3 _____ Hep. C _____ SPEP _____ Other: _____

MPO _____ C4 _____ HIV _____ Free LC Ratio _____ Other: _____