UFHealth
PATHOLOGY LABORATORIES

ALL ORANGE AREAS ARE REQUIRED.

Practice Name: _____

Address: _____

E-mail: _____

Phone: _____ Fax: _____

RENAL/MUSCLE/NERVE PATHOLOGY REQUISITION

http://pathlabs.ufl.edu

Patient information*

Collection date: _____ Time: ____ : ____ A.M./P.M.

Name (last, first, middle initial): Sex: Male Female

_____

Date of birth (MM/DD/YYYY): _____

Medical record/Patient ID#: _____

Billing information*

You MUST include copies of the patient's demographics sheet and both sides of the patient's insurance card(s), along with any secondary insurance information (if applicable), with this requisition.

Provider information

Ordering physician: _____

Ordering physician NPI #: _____

Phone: _____ Fax: _____

Pathologist: _____

Duplicate report sent to: _____

Phone #: _____ Fax #: _____

Clinical information for muscle/nerve biopsies

Clinical question/Differential diagnosis (Attach clinical notes.):

_____

_____

_____

Biopsy site: _____

Weakness: ☐ Proximal ☐ Distal

Illness duration: ☐ Acute ☐ Chronic

Immunosuppressive treatment administered to the patient prior to biopsy (e.g. steroids)?: ☐ Yes ☐ No

Results of nerve conduction/EMG studies: _____

_____

Clinical information for renal biopsies

Biopsy: ☐ Native ☐ Transplant

Clinical syndrome under evaluation (Check all that apply.):

☐ Acute renal failure ☐ Chronic renal failure ☐ Proteinuria

☐ Nephrotic syndrome ☐ Nephritic syndrome ☐ Hematuria (micro)

☐ Rapidly progressive glomerulonephritis ☐ Hematuria (macro)

☐ Diabetes ☐ Hypertension ☐ Drug history

☐ Family history of renal disease

☐ Transplant follow-up | Date of transplant: _____

Narrative history/Data (Provide clinical notes below.)

_____

_____

_____

Relevant labs:

☐ Serum creatinine (mg/dL): _____

☐ Glomerular filtration rate (GFR): _____

☐ Urine protein: _____

☐ Hemoglobin A1c: _____

C3: ☐ Low ☐ Normal

C4: ☐ Low ☐ Normal

Designate if positive (P) or negative (N):

ANA: ☐ P ☐ N pANCA: ☐ P ☐ N cANCA: ☐ P ☐ N

Hep. B: ☐ P ☐ N Hep. C: ☐ P ☐ N dsDNA: ☐ P ☐ N

HIV: ☐ P ☐ N Cryo.: ☐ P ☐ N Anti-GBM: ☐ P ☐ N

Monoclonal protein serum: ☐ P ☐ N

Monoclonal protein urine: ☐ P ☐ N

Referring MUSCLE/NERVE DOCTOR to contact with results?

☐ Rush (Before sending any rush cases, call us at **352.265.9900** to provide contact details for the person who will receive the results.)

Name: _____

Phone #: _____ Fax #: _____

Referring KIDNEY DOCTOR to contact with results?

☐ Rush (Before sending any rush cases, call us at **352.265.9900** to provide contact details for the person who will receive the results.)

Name: _____

Phone #: _____ Fax #: _____

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