UFHealth
PATHOLOGY LABORATORIES

Practice name _____
Address _____
Email _____
Phone _____ Fax _____

RENAL/MUSCLE/NERVE PATHOLOGY REQUISITION

PATIENT INFORMATION

Collection Date _____ **Time** _____ ☐ A.M. ☐ P.M.

Full Name (last, first, MI) _____

Sex: ☐ Male ☐ Female

Date of birth (MM/DD/YYYY) _____

MRN# / Patient ID# _____

Critical Call Back

Direct _____

Cell _____

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's 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: _____

_____

Indication of Biopsy:

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

Brief Clinical History: _____

Family history of kidney disease: ☐ Yes ☐ No

CLINICAL INFORMATION FOR RENAL BIOPSIES

Biopsy: ☐ Native ☐ Transplant **Biopsy Tissue Type:** ☐ 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

Transplant—

AsA/Tacrolimus_____ Native Kidney Disease_____
DSA_____ Date of Transplant_____ Donor: ☐ Living ☐ Deceased

Labs—

S.Creatinine_____ mg/d 24 Hour Urine Protein _____ Hgb A1C _____
Hematuria _____ GFR _____ Urine Prot: Cr Ratio_____
Serum Albumin_____ Hgb_____ Platelets _____

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:_____

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** _____

PS161312-12/10/21

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** _____