

**UW Medicine**  
PATHOLOGY

**Renal Transplant Biopsy Requisition Form**

Anatomic Pathology, Box 356100

**Room BB220D**

Seattle, WA 98195-6100

Ph. 206.598.2030, Fax 206.598.4928 (Accessioners)

Ph. 206.598.6061 (Renal Biopsy Technologist)

UWMC PATIENT NO.		UWMC ACCESSION NO.	
PATIENT NAME		DATE OF BIRTH	
AGE	SEX	HEIGHT	WEIGHT

1) TODAY'S DATE: \_\_\_\_\_

2) PREVIOUS BIOPSY: YES / NO (If YES, date of previous biopsy: \_\_\_\_\_)

3) TRANSPLANT DETAILS: Transplant date: \_\_\_\_\_

TYPE:  K alone,  KP,  other \_\_\_\_\_

4) ORIGINAL CAUSE OF RENAL FAILURE: \_\_\_\_\_

5) INDICATION FOR Bx:  Protocol biopsy or  Clinical / Follow-up \_\_\_\_\_

6) LABORATORY INVESTIGATION:

Serum creatinine \_\_\_\_\_mg/dl  acute rise,  chronic rise,  failure to decline

Proteinuria YES / NO \_\_\_\_\_

Donor specific antibodies YES / NO \_\_\_\_\_

7)

Clinical Impression	Definite	Suspected	Comments
Acute Rejection			
Acute Tubular Necrosis			
Chronic Rejection			
Calcineurin inhibitor toxicity			
BK polyomavirus infection			<input type="checkbox"/> Request SV40
Recurrent GN			
Severe Hypertension			
Other			

8) CURRENT IMMUNOSUPPRESSION

Medication	Dose / Level	Medication	Dose / Level
Prednisone		Azathioprine	
Mycophenolate (MMF)		Cytoxan	
FK506		Leflunomide	
Cyclosporine		Other	
Sirolimus			

Requesting Physician: \_\_\_\_\_ Pager, cell: \_\_\_\_\_