



UNC DIVISION OF NEPHROPATHOLOGY

RENAL BIOPSY SPECIMEN REFERRAL FORM

—For Renal Allograft Biopsies—

Send this referral form with tissue to:

UNC Division of Nephropathology
409 Brinkhous-Bullitt Bldg.
Department of Pathology CB#7525
UNC School of Medicine
Chapel Hill, NC 27599-7525

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Downloadable forms and further instructions can be found at our website: www.uncnephropathology.org

<p><u>REFERRING HOSPITAL/INSTITUTION</u></p> <p><u>Pathologist:</u></p> <p><u>Hospital:</u></p> <p><u>Address:</u></p> <p><u>Phone:</u></p> <p><u>FAX:</u></p>	<p><u>REFERRING PHYSICIAN</u></p> <p><u>Nephrologist:</u></p> <p><u>Address:</u></p> <p><u>Phone:</u></p> <p><u>FAX:</u></p> <p><u>Email:</u></p>
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PATIENT INFORMATION

DATE OF BIOPSY: _____ **Biopsy Description:** _____
 (length) **Formalin** **Michel's** **Glutaraldehyde**

Name: _____
 (Last name) (First name) (Middle name or initial)

Race: _____ **Sex:** male / female **Date of birth:** _____ **Age:** _____

Date when current transplant was implanted: _____
 (Month/Day/Year)

Previous Transplant Biopsies? Yes No

If Yes, previous transplant biopsy diagnosis: _____

Underlying Native Kidney Disease:
Was the diagnosis established by Biopsy? Yes No

Previous Kidney Transplants? Yes No

If Yes, is this the: first/second/third/fourth/fifth transplant

Reason for previous graft loss:

Is this Reason Presumed or Biopsy-Proven?

Age of Most Recent Donor: _____ **Sex:** Male / Female **Race:** _____

Donor: Cadaveric / Living Related / Living Unrelated

Ischemia (approx. time): Warm _____ (min.)/Cold _____ (min.)

Delayed Graft Function: Yes No Undecided
 (During first week after transplant) **If yes, how many days of hemodialysis:** _____

Indication for current biopsy: **Baseline-Biopsy (0-Hour)** **“Protocol Biopsy”**
Diagnostic Biopsy **Transplant**
Nephrectomy

Current Immunosuppression	CyA	<input type="checkbox"/>	FK-506/Tacrolimus	<input type="checkbox"/>
	Steroids	<input type="checkbox"/>	Azathioprine	<input type="checkbox"/>
	MMF/CellCept/Myfortic	<input type="checkbox"/>	Rapamycin/Sirolimus	<input type="checkbox"/>
	ATG / ALG / OKT3 / Thymoglobulin	<input type="checkbox"/>		
	IVIg	<input type="checkbox"/>	Rituximab (anti-CD 20)	<input type="checkbox"/>
	Anti-CD25 antibody (e.g. basiliximab)	<input type="checkbox"/>		
	Campath-1 (Alemtuzumab)	<input type="checkbox"/>	Other _____	

Drug Levels ("eg CyA or FK trough levels")	Low	<input type="checkbox"/>	expected target range	<input type="checkbox"/>
	High	<input type="checkbox"/>	unknown	<input type="checkbox"/>

Specific anti-rejection treatment before biopsy (within last week) **Yes** **No**

If yes, what was the type of preceding anti-rejection treatment:

OKT3	<input type="checkbox"/>	Bolus steroid	<input type="checkbox"/>	Thymoglobulin/ATG	<input type="checkbox"/>
Radiation	<input type="checkbox"/>	Plasmapheresis	<input type="checkbox"/>	IVIg	<input type="checkbox"/>
Rituximab (anti-CD 20)	<input type="checkbox"/>	Tacrolimus (rescue protocol)	<input type="checkbox"/>	Other _____	

Patient is currently off all immunosuppression?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Patient seems compliant?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Patient is currently back on hemodialysis?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Evidence of antibodies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If yes, titer specificity? _____

Blood Pressure (mmHg) _____ / _____ (systolic/diastolic)

Proteinuria: 0 / + / ++ / +++ (_____ gm/24hrs)

Hematuria: **Yes** **No**

Suspicion of Glomerulonephritis? **Yes** **No**

Urine Sediment: **Active** **Inactive** **Not Checked**

Serum Creatinine (present peak): _____ mg % (_____ µmol/l)

Serum Creatinine (baseline level, previous 3 months): _____ mg% (_____ µmol/l)

Clinical Signs of Infection at time of current Biopsy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
1. Polyoma(BK)virus	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
If yes, specify:	Plasma PCR	_____	Decoy Cells	_____	Urine PCR	_____
2. CMV	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
3. Herpes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
4. Hepatitis B/C	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
5. Adenovirus	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
6. EBV	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
7. Bacteria	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
8. Fungi	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
9. Urinary Tract	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
Other infections _____						

Stenosis of renal artery	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
Obstruction of Ureter	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
Lymphocele	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Undecided	<input type="checkbox"/>
