



UNC NEPHROPATHOLOGY SERVICE

RENAL BIOPSY SPECIMEN REFERRAL FORM

—For Renal Allograft Biopsies—

INSTRUCTIONS

1. Obtain tissue and partition for LM, IM and EM.
To avoid contamination, always put the same cap back on the vial.
2. Place tissue for light microscopy (LM) in Buffered Formalin
3. Place tissue for immunofluorescence microscopy (IM) in Transport Medium.
4. Break glutaraldehyde ampoule; empty into vial labeled Glutaraldehyde.
Place tissue for EM in buffered glutaraldehyde.
5. Fill in parts 1, 2 and 3 of this referral form.

UNC Nephropathology Lab does not bill patients or insurance.
Bill for services will be directed to the referring institution below.
Cost of shipping the specimen is the responsibility of the sender.

6. Please notify UNC Nephropathology prior to sending a biopsy.
7. Send this referral form with tissue to:

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

Tel: (919) 966-2421
 FAX: (919) 966-4542

| | |
|--|---|
| <p>PART 1: SEND BILL AND REPORT TO: Enter name and address of the referring institution to receive the report, bill, slides and micrographs. SPECIMEN # OF REFERRING INSTITUTION: _____ <u>Pathologist:</u> _____ <u>Hospital:</u> _____ <u>Address:</u> _____ <u>Phone:</u> _____ <u>FAX:</u> _____</p> | <p>PART 2: SEND REPORT TO: Enter the name and address of the nephrologist who will be sent a copy of the report. <u>Nephrologist:</u> _____ <u>Address:</u> _____ <u>Phone:</u> _____ <u>FAX:</u> _____</p> |
|--|---|

PART 3: PATIENT INFORMATION

DATE OF BIOPSY: _____

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

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

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?

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

Previous Transplant Biopsies? Yes No
 If Yes, previous transplant biopsy diagnosis:

Indication: 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"/> | Other _____ | |
| | Campath-1 (Alemtuzumab) | <input type="checkbox"/> | | |

| | | | | |
|---|-------------|--------------------------|------------------------------|--------------------------|
| 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"/> | Undecided | <input type="checkbox"/> |
| If yes, titer specificity? | _____ | | | | | |
| Blood Pressure (mmHg) | _____/_____ (systolic/diastolic) | | | | | |
| Proteinuria: | 0 / + / ++ / +++ (____gm/24hrs) | | | | | |
| Hematuria: | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | | |
| Suspicion of Glomerulonephritis? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | | |
| Urine Sediment: | _____ | | | | | |
| 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** **No** **Undecided**

1. Polyoma(BK)virus **Yes** **No** **Undecided**

If yes, specify: _____ **Decoy Cells** _____ **Urine PCR** _____ **Plasma 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"/> |

| | | |
|---------------------------------|--|--------------------|
| Age of Donor: _____ | Sex: Male / Female | Race: _____ |
| Donor: | Cadaveric / Living Related / Living Unrelated | |
| Ischemia (approx. time): | Warm _____ (min.) / Cold _____ (min.) | |

Delayed Graft Function: (During first week after transplant) **Yes** **No** **Undecided**

If yes, how many days of hemodialysis _____