



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

Telephone: (919) 966-2421
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Downloadable forms and further instructions can be found at our website: www.uncnephropathology.org

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

PATIENT INFORMATION ***PLEASE ALSO ATTACH ANY ADDITIONAL HISTORY*** (RECENT LABS, OFFICE NOTES, ETC.)

DATE OF BIOPSY: _____

Referring hospital patient number: _____

The patient is (please circle one): Inpatient/ Outpatient

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 / 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"/>
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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"/>
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1. Polyoma(BK)virus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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If yes, specify: **Plasma PCR** _____ **Decoy Cells** _____ **Urine PCR** _____

2. CMV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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3. Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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4. Hepatitis B/C	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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5. Adenovirus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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6. EBV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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7. Bacteria	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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8. Fungi	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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9. Urinary Tract	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undecided <input type="checkbox"/>
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Other infections _____

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