UW Medicine
PATHOLOGY

Renal Transplant Biopsy Requisition Form

Anatomic Pathology, Box 356100
Room BB220D
Seattle, WA 98195-6100
Phone: (206) 598-6400
Supplies, Fax: (206) 598-8049

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			☐ Request SV40
Recurrent GN			
Severe Hypertension			
Other			

8) CURRENT IMMUNOSUPRESSION

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

Requesting Physician: _____ Pager, cell: _____