



# Hennepin County Medical Center

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# Renal Biopsy Interpretation Request

HCMC Accession # \_\_\_\_\_

Date/Time Received: \_\_\_\_\_

### PATIENT INFORMATION

Last Name  First Name  MI

Date of Birth   Male  Female Phone  Marital Status

Address  City  State  Zip Code

Employer  Employer Address

### BILLING AND INSURANCE INFORMATION

Bill to:  Patient (send insurance informatin and demographics)  Hospital/Clinic

### SUBMITTING INSTITUTION

Hospital/Clinic/Group Name

Address  City  State  Zip Code

Phone  Fax  E-mail

### PHYSICIAN INFORMATION

Requesting MD  Nephrologist (if not requesting)

Call Results to: Name  Phone:  Fax Results to: Name  Phone:

Send Additional Copy to:

### SPECIMEN INFORMATION

Collection Date  Collection Time

Accession Number

Tests Requested:  Light Microscopy (Red Vial - Formalin)  
 Immunofluorescence Microscopy (Yellow Vial - Zeus)  
 Electron Microscopy (Green Vial - Glutraldehyde)

### CLINICAL INFORMATION

**Patient Location:**  Inpatient  Outpatient

**Biopsy Site:**  Native Right Kidney  Native Left Kidney  Transplant (Allograft) Biopsy

Date of Transplant

Original Disease

**Indication for Biopsy:**  Diabetes  Acute Renal Failure  Family History  Hematuria  
 Systemic Lupus  Transplant Rejection  Proteinuria  Hypertension  Other:

### Urinalysis/Urine Tests:

Hematuria \_\_\_\_\_ Proteinuria \_\_\_\_\_ Pr/Cr \_\_\_\_\_ 24hr Protein \_\_\_\_\_

Pyuria \_\_\_\_\_ RBC Casts \_\_\_\_\_ Creatinine Clearance \_\_\_\_\_

### Serum Tests:

Creatinine \_\_\_\_\_ Albumin \_\_\_\_\_ Cholesterol \_\_\_\_\_ ANA \_\_\_\_\_ ANCA \_\_\_\_\_ Anti-ds DNA \_\_\_\_\_ Anti-GBM \_\_\_\_\_

HIV \_\_\_\_\_ ASO \_\_\_\_\_ SPEP/UPEP \_\_\_\_\_ Hepatitis B/C \_\_\_\_\_ C3/C4 \_\_\_\_\_

Other \_\_\_\_\_

### Other Pertinent Clinical Information: