

Practice Name: _____

Address: _____

E-mail: _____

Phone: _____ Fax: _____

Patient information*

Collection date: _____ Time: _____ : _____ A.M./P.M.

Name (last, first, middle initial): _____ Sex: _____ Male _____ Female _____

Date of birth (MM/DD/YYYY): _____

Medical record/Patient ID#: _____

Billing information*

****You MUST include copies of the patient's demographics sheet and both sides of the patient's insurance card(s), along with any secondary insurance information (if applicable), with this requisition.****

Provider information

Ordering physician: _____

Ordering physician NPI #: _____

Phone: _____ Fax: _____

Pathologist: _____

Duplicate report sent to: _____

Phone #: _____ Fax #: _____

Clinical information for muscle/nerve biopsies

Clinical question/Differential diagnosis (Attach clinical notes.):

Biopsy site: _____

Weakness: Proximal Distal

Illness duration: Acute Chronic

Immunosuppressive treatment administered to the patient prior to biopsy (e.g. steroids)?: Yes No

Results of nerve conduction/EMG studies: _____

Referring **MUSCLE/NERVE DOCTOR** to contact with results?

Rush (Before sending any rush cases, call us at 352.265.9900 to provide contact details for the person who will receive the results.)

Name: _____

Phone #: _____ Fax #: _____

Clinical information for renal biopsies

Biopsy: Native Transplant

Clinical syndrome under evaluation (Check all that apply.):

- Acute renal failure Chronic renal failure Proteinuria
- Nephrotic syndrome Nephritic syndrome Hematuria (micro)
- Rapidly progressive glomerulonephritis Hematuria (macro)
- Diabetes Hypertension Drug history
- Family history of renal disease
- Transplant follow-up | Date of transplant: _____

Narrative history/Data (Provide clinical notes below.)

Relevant labs:

- Serum creatinine (mg/dL): _____
- Glomerular filtration rate (GFR): _____
- Urine protein: _____
- Hemoglobin A1c: _____

C3: Low Normal

C4: Low Normal

Designate if positive (P) or negative (N):

ANA: P N pANCA: P N cANCA: P N

Hep. B: P N Hep. C: P N dsDNA: P N

HIV: P N Cryo.: P N Anti-GBM: P N

Monoclonal protein serum: P N

Monoclonal protein urine: P N

Referring **KIDNEY DOCTOR** to contact with results?

Rush (Before sending any rush cases, call us at 352.265.9900 to provide contact details for the person who will receive the results.)

Name: _____

Phone #: _____ Fax #: _____

RENAL/MUSCLE/NERVE PATHOLOGY REQUISITION

http://pathlabs.ufl.edu