Renal Pathology

Please check one: □ Inpatient  □ Outpatient  □ Ambulatory Surg Center

Clinical History: Respond below and/or attach patient’s most recent clinical history. Please provide ICD Diagnosis Codes in Section 5 above.

Reason for biopsy:__________________________________________________________

Blood Pressure:________ Creatinine:_______ Creatinine Clearance:________ Complements:________________

Urineysis____________________________________ Cholesterol:________ Blood Glucose:________

Albumin:_________ UPEP:_________ SPEP:____________

Serologies:ANA:________ ASO:________ HIV:________ ANCA:________ HEP/B/C:________

Other pertinent history or lab data:_________________________________________________________________

Referring Physician Information: (If different from Ordering Physician/Client Information box at top)
Nephrologist:____________________________________ Fax a final Report? Yes____ No____
Address:________________________________________ Fax:________________
City, State, Zip________________________________ Telephone:________________

Please FAX this submission form and face sheet to the 317-491-6419 BEFORE sending all biopsies:
Attention: Renal Biopsy

□ Check box if this biopsy is critical and is being shipped on Friday for “Saturday Delivery.”