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

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 IMMUNOSUPPRESSION

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose / Level</th>
<th>Medication</th>
<th>Dose / Level</th>
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</thead>
<tbody>
<tr>
<td>Prednisone</td>
<td></td>
<td>Azathioprine</td>
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<tr>
<td>Mycophenolate (MMF)</td>
<td></td>
<td>Cytoxan</td>
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<td>FK506</td>
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<td>Leflunomide</td>
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<tr>
<td>Cyclosporine</td>
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<td>Other</td>
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<tr>
<td>Sirolimus</td>
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</tbody>
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Requesting Physician: ___________________________ Pager, cell: __________________________