BCRenal
Provincial Health Services Authority

Renal Biopsy Request Form

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

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

PHN: _____

▶ PLEASE SIGN, DATE AND FAX THIS FORM TO:
St. Paul's Hospital (Vancouver) 604-806-8701

Date of biopsy: _____ Ordering physician: _____

Additional recipients of report: _____

☐ Urgent biopsy, call with results ➡ Phone number: _____

☐ Patient has had a previous biopsy ➡ Date or surgical number: _____

PRE-BIOPSY DIAGNOSIS

CLINICAL SYNOPSIS

MEDICATIONS

History of nephrotoxin exposure? ☐ YES ☐ NO If YES, which one? _____

Blood pressure: _____/_____ Weight: _____ Height: _____

Pattern of Renal Failure

Mode of creatinine change:	☐ Acute rise	☐ Gradual rise	☐ Failure to fall
Is patient oliguric:	☐ Yes	☐ No	

Transplant Details

Date of transplant:			**Transplant number:**
Type of transplant:	☐ Deceased donor	☐ Living donor	**Original disease:**

BC Children's Hospital · fraserhealth Better health. Best in health care. · Interior Health · island health · northern health · Providence Health Care How you want to be treated. · Vancouver Coastal Health Promoting wellness. Ensuring co

Comorbidities

Self-reported race:

- ☐ Arab
- ☐ Black
- ☐ Chinese
- ☐ Filipino

Indigenous:

- ☐ First Nations
- ☐ Inuit
- ☐ Metis

- ☐ Japanese
- ☐ Korean
- ☐ Latin American
- ☐ Other/ Multiracial
- ☐ South Asian (e.g. East Indian)

- ☐ Southeast Asian (e.g. Cambodian)
- ☐ Unknown
- ☐ West Asian (e.g. Iranian, Afghan)
- ☐ White

Cardiovascular:

- ☐ Cerebrovascular disease _____
- ☐ Congestive heart failure _____
- ☐ Coronary artery disease _____
- ☐ Hypertension _____
- ☐ Peripheral vascular disease _____
- ☐ Pulmonary hypertension _____
- ☐ VTE Location:_____

Endocrine:

- ☐ Diabetes _____
- ☐ Dyslipidemia _____
- ☐ Thyroid disease (pick one) ☐ Hyper ☐ Hypo

GI:

- ☐ Cirrhosis _____
- ☐ Infectious hepatitis _____
- ☐ Inflammatory bowel disease _____

Lifestyle Factors:

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Smoker (choose one) ☐ Current ☐ Former

Malignancy:

- ☐ Solid organ cancer Location:_____
- ☐ Hematologic cancer Type:_____
- ☐ Melanoma _____

Pregnancy:

- ☐ Pre eclampsia _____
- ☐ Pregnant currently _____

Respiratory: _____

- ☐ Asthma _____
- ☐ COPD _____
- ☐ Sleep Apnea _____

Rheumatologic:

- ☐ Lupus _____
- ☐ Rheumatoid arthritis _____
- ☐ Scleroderma _____
- ☐ Sjogren's syndrome _____

Other:

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Laboratory Data

		H/N/L*
Creatinine		
eGFR		
ANA titre		
Anti-dsDNA level		
ANCA		
Anti-GBM Ab		
C3 level		
C4 level		
ESR or CRP		
Other:		
SPEP		
UPEP		
Virology: HIV Hep B Hep C		
24-hour urine protein		
Urine ACR		
Urine PCR		
Urinalysis: RBC WBC Casts Other		

*** High/Normal/Low**

Date: _____

Signature: _____

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