DUKE UNIVERSITY HEALTH SYSTEM

INSTRUCTIONS FOR OBTAINING AND SENDING KIDNEY BIOPSY

Kits for biopsies are provided by the Immunopathology Laboratory in Duke South. / Please call if you need more kits - (919) 684-8431.

Storage Instructions:

Store glutaraldehyde (4% cacodylate-buffered glutaraldehyde) in the refrigerator at 4°C. DO NOT FREEZE.
Store formalin (10% neutral buffered formalin) at room temperature in the box it was shipped in.
Store immunofix (Michel's transport medium) at room temperature in the box it was shipped in.

Directions:

Subdivide tissue for light, immunofluorescence and electron microscopy. Place a representative sample of the biopsy into each of the three fixative vials; avoid cross-contamination of fixatives. Do not use the glutaraldehyde fixative if it is YELLOW. Store the tissue in the glutaraldehyde fix in the refrigerator until ready to ship. Fill out the paperwork with the required information. Place all sample vials and the paperwork in the kit box and send.

PATIENT INFORMATION:

Name:_____ Age:_____ Date of Birth:_____

Male/Female (circle one) Race:_____

History and Clinical Diagnosis:

☐ Inpatient or ☐ Outpatient

Symptoms and Signs:

Blood Pressure:_____ Edema___ Arthritis/Arthralgias___ Skin Lesions____ Other:_____

Laboratory Data:

Urine

Sediment
Hematuria Proteinuria_____ _____gm/24 hr Proteinuria
Other:

Serum

Creatinine BUN Creatinine Clearance
Albumin Cholesterol
Complement
ANA Anti-DNA ASO
ANCA HBsAg Other:_____

Therapy:

Procedure Performed:	Date of Procedure:

DukeHealth | DUHS Clinical Laboratories

Wet Tissue Laboratory Request Form

This form MUST be filled out COMPLETELY and ACCURATELY in order to proceed with the review of your case.

ALL cases must include a Pathology Report (gross only is fine) and an ICD-10.

If you have any questions please contact **DUHS Immunochemistry Lab** at **(919) 681-9483 or the Lab Manager at (919) 684-5822.**

Patient Name: (last, first, middle)	**Nephrologist's Name:**
Date of Birth (mm/dd/yyyy)	**NPI#:** **UPIN#:**
Social Security Number: (for identification purposes only) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	**Nephrologist's Mailing Address:**
Gender: ☐ **Male** ☐ **Female**	**Pager#:** **Phone#:** **Fax#:**
Patient Mailing Address:	

Type of Tissue Submitted:	**Date Collected:**
Type of Testing or Review being requested:	

The outside submitting facility is financially responsible for any charges related to requests for laboratory services. Please complete the information below for invoicing purposes.

Name of Hospital:	**Attention To:**
Address:	**Phone #:** **Fax#:**
Ship To: **Duke Clinical Laboratories/** **Immunochemistry Lab** **4063 Duke South Clinics, Yellow Zone** **40 Duke Medicine Circle, Trent Drive** **Durham, NC 27710** **Phone: 919-681-9483**	

Revised 8/15/2018