ELECTRON MICROSCOPY SERVICE LABORATORY, UCSF

Request for Consultation

UCSF Use Only: UCSF Accession Number_____

Patient Name:
_____

Birth Date: _____ Sex: _____

Referring Hosp. MRN_____

Referring Hospital: _____

Address**:** _____

_____

DATE COLLECTED_____

Materials submitted for Evaluation:

Case Number_____

___ **Wet Tissue**
___ **Paraffin block**
___ **Light microscopy slides**

___ **Other**_____

Studies Requested:

___ **Light Microscopy**

___ **Immunofluorescence**

___ **Electron Microscopy**

Due to HIPAA regulations please list ALL address / FAX# to which reports are to be sent***
******Leaving these blank may result in failure to receive a report***

Referring Physician:

_____
(Full name)

Physician Address:
_____

_____

Fax: (REQUIRED)_____

Referring Pathologist:

_____
(full name)

Pathology Dept. Address:
_____

_____

Dept PHONE: _____

Fax: (REQUIRED)_____

Preliminary telephone report to:

_____Phone #_____

Please Bill: ____ **Hospital** ____**Insurance** _____**Patient**

Billing: Insurance Authorization is required for the following CPT codes.

UCSF will bill submitting institution if insurance authorization is not received.

CPT Codes for Renal workup: 88305 x**1**, 88313 x **4**, 88346 x **1**, 88350 x **9**, 88348 x **1**

CPT Code for Electron Microscopy workup only (i.e., blood, cilia, liver, tumor): 88348 x **1**.

Presenting History:

Past Medical History

Chronic Renal Failure:	Y / N	for _____Years
Hypertension:	Y / N	for _____Years
Diabetes Mellitus:	Y / N	for _____Years
Immune Compromised:	Y / N	
IV Drug Use:	Y / N	

Physical Examination
BP: _____/ _____
Fundi: _____
Edema_____

Renal transplantation: Y / N
Date: _____
Primary Disease: _____
Conn. Tissue Disease: Y / N Specify_____
Malignancy: Y / N Specify_____
Family History of Renal Disease:

Medications:

Laboratory Results (pertinent to differential diagnosis)

Serum
Hematocrit
Schistocytes: Y / N
WBC: % Eos:
Platelets:
BUN:
Creatinine:
Albumin:
Other:

Electrophoresis
SPEP:
UPEP:

Additional Studies (Ultrasound, IVP, CT):

Urinalysis
Proteinuria:_____ for_____
Hematuria _____ for_____

Sediment
RBCs:
RBC Morphology:
WBCs:
Casts:
Other:

24-Hour Collection:
Protein:
CrCl:

Serology
ANA:
Anti-ds DNA:
ASO:
Anti-DNAse B:
Anti-GBM:
ANCA:
C3:
C4:
Cryoglobulin:
Hepatitis Serology:
Other:

Deliver to: **(Please write address as shown to ensure proper delivery)**	UCSF Electron Microscopy Laboratory Pathology Department 513 Parnassus Ave, Room S-570 San Francisco, CA 94143	Ph: (415) 353-2673 (call for fixatives) FAX: (415) 514-3403 Request Form and instructions download: https://pathology.ucsf.edu/consultation-services/renalpath