VANDERBILT UNIVERSITY MEDICAL CENTER
REQUEST FOR DIAGNOSTIC IMMUNOFLUORESCENCE
Division of Electron Microscopy/Renal Pathology Laboratory
C2317 Medical Center North, Nashville, TN 37232-2561
Phone (615) 322-3070 * Fax (615) 322-4840**

To ensure faster service, please fill in all spaces completely when submitting tissue for IF.

Patient's Name: _____Age_____Date of Birth: _____ Sex/Race:_____

Accession Number: _____ Medical Record Number: _____

Clinician's Name: _____ Pathologist's Name: _____

Tissue submitted in: Michel's_____ or Saline: (use for heart) _____

Clinical History: _____

Immunofluorescence Studies Requested: _____Routine Panel:_____

C4d_____ Tissue source: _____

REQUESTING OUTSIDE FACILITY INFORMATION (do not need to complete for in-house cases).

Inpatient: _____ or Outpatient: _____ Bill Insurance:_____ Bill Client:_____

If applicable, please include all billing information for Patient-Bill Cases. Paperwork without insurance information would be billed to the clients.

OUTSIDE PATHOLOGIST'S NAME, HOSPITAL NAME & ADDRESS: _____

_____

_____

_____

PHONE: _____ FAX NUMBER:_____ UPIN Number: _____

REQUESTING CLINICIAN'S NAME, FACILITY NAME & ADDRESS: _____

_____

_____

_____

PHONE:_____ FAX NUMBER:_____ UPIN Number: _____