Rex Hospital Pathology Department

Liver Biopsy Patient Information

Please complete this form and submit along with histology requisition for patients having liver biopsies performed at Rex Hospital. This will assist in the efficient and accurate evaluation of the biopsy, while minimizing the need for additional studies/stains. For biopsies to be performed under CT guidance, please FAX the completed form to the Rex Radiology Department at 784-3094.

Patient Name: _____ _____ _____
(Last Name) **(First Name)** **(Middle Name/Initial)**

Date of Birth: ____/____/_____

Physician Name: _____

Diagnosis/Reason for Biopsy: _____

Viral Hepatitis Serology: _____

AST/SGOT: _____ **ALT/SGPT:** _____ **Alk Phos:** _____

Bilirubin: _____ **Albumin:** _____ **Tot. Protein:** _____

Iron Studies: _____

Antimitochondrial Ab: _____ **Anti-Smooth Muscle Ab:** _____

Antinuclear Ab: _____

PT/INR (Normal Range): _____(_____) **Date:** _____

PTT (Normal Range): _____(_____) **Date:** _____

Other pertinent clinical information or laboratory data: