

Please send required documentation

- Face sheet (insurance)
- Clinical History

Neuromuscular Pathology Request Form

PATIENT & ORDERING INFORMATION (please clearly print name or attach patient sticker)	
Patient Name:	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Hospital/Clinic:	Referring Physician:
MRN or Accession #:	Tel: Fax:
	Send Results to: Fax:

SPECIMEN INFORMATION	
Biopsy Date:	Time:
Specimen Type: <input type="checkbox"/> Skeletal Muscle Biopsy <input type="checkbox"/> Peripheral Nerve Biopsy	Site(s): Site(s):

TESTING REQUESTED	SPECIMEN MEASUREMENTS (For Neuromuscular Lab to Complete)
<input type="checkbox"/> Light Microscopy and Histochemistry <input type="checkbox"/> Electron Microscopy <input type="checkbox"/> Nerve Teasing **Please indicate proximal end** Additional immunohistochemistry or biochemistry testing may be ordered by the reading neuromuscular pathologist based on initial evaluation. Please contact us prior to sending the specimen with any questions regarding additional testing.	<input type="checkbox"/> Fresh (Saline Moistened Gauze- NOT DRIPPING!) <input type="checkbox"/> EM Fixative <input type="checkbox"/> Frozen (Dry Ice) <input type="checkbox"/> Formalin Fixed

DIAGNOSIS/INDICATION FOR TESTING & RELEVANT CLINICAL HISTORY

BILLING INFORMATION

Bill Hospital or Clinic Listed Above

Bill Patient Directly

Medicare billing policy prevents us from submitting a Medicare claim for laboratory testing referred to us on hospital inpatients or hospital outpatients. For these samples, we will bill the sending hospital.

Signature of Physician

Date