NEUROMUSCULAR PATHOLOGY REQUEST FORM

HCMC Surg. Pathol. No. _____

Hennepin County Medical Center
Neuromuscular Pathology Laboratory
825 South 8th Street, Suite LL-05
Minneapolis, MN 55404
Tel 612-873-2175
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(Please fill in or use label)

Patient Name	**Date of Biopsy** **Time**
Date of Birth **Sex**	**Physician** **Tel**
Hospital/Clinic	**Physician** **Tel**
Medical Record No.	**Physician** **Tel**
Laboratory Telephone	**Report to** **Fax**

SPECIMEN: [ ] **Muscle**_____ [ ] **Nerve** _____ [ ] **Lymphocyte Lysosomal Analysis**
[ ] **Skin**_____ [ ] **Fascia** _____ **(EDTA Blood Tube)**

STUDIES REQUESTED: [ ] **Light microscopy and histochemistry** [ ] **Electron microscopy** [ ] **Biochemistry**
[ ] **Nerve Teasing** [ ] **Other**

SPECIMEN PRESERVATION/SHIPMENT: [ ] **Saline soaked gauze** [ ] **EM Fixative** [ ] **Frozen (Dry Ice)** [ ] **EDTA Tube**
[ ] **Michel's transport media**

CLINICAL HISTORY/DIAGNOSIS:

BILLING INFORMATION

[ ] Bill Hospital or Clinic Listed Above [ ] HFA/HCMC [ ] Bill Patient Directly
Please provide billing information

INSURANCE COMPANY:	MEDICARE INFORMATION
Employer: Group Number:	Medicare #:
Plan I.D. Number:	MEDICAID INFORMATION:
Plan Mailing Address:	Medicaid #: If not MN, list the state MA coverage is with:
Responsible Party: Relationship:	**PATIENT Address:**
Resp. Party Address:	**Telephone:** **SSN:**

For Neuromuscular Laboratory Use
Specimen(s) Received Fixation Sizes MW Processing Time