Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Electron Microscopy Patient Information

Instructions: To help provide the best possible service, supply the information requested below and send paperwork with the specimen.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Pathologist Name *(Last, First)*	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

- ☐ CADASIL
- ☐ Ciliary morphology (eg, primary ciliary dyskinesia)
- ☐ Connective tissue disorder, specify:
- ☐ Other:
- ☐ Mitochondrial disorder, specify:
- ☐ Storage disease, specify:
- ☐ Tumor, specify:

Patient History/Pathologist Comments

Specimen Fixative

☐ Trumps fixative	☐ 2.5%–3% Glutaraldehyde	☐ Other (call lab before submitting)

Specimen Type

☐ Skin ☐ Whole blood ☐ Ciliary brushing ☐ Buffy coat ☐ Nasal ☐ Trachea ☐ Heart

☐ Other:

Print

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