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)*	Gender ☐ 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

☐ Connective tissue disorder, specify: _____

☐ Microvillous inclusion disorder

☐ Mitochondrial disorder, specify: _____

☐ Storage disease, specify: _____

☐ Tumor, specify: _____

☐ Other: _____

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 ☐ Liver ☐ Trachea ☐ Duodenum ☐ Heart

☐ Other: _____

Print