



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

**Patient Information** (required)

Patient Name <i>(Last, First, Middle)</i>		Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Referring Neurologist Name <i>(Last, First)</i>		Phone	Fax*	
Neurologist Address		City	State	ZIP Code

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

**Reason for Testing and Clinical Information**

All information below is **required**. Specimens will not be processed if information is not completed.

\*\*Use only fixative, buffer, and cryoprotectant provided in the kit by Mayo Clinic Laboratories.\*\*

Tissue Name (example: 3mm skin punch)			Procedure Date <i>(mm-dd-yyyy)</i>
<b>Biopsy Site: 1</b>	<b>Body Side</b>	Amount of time tissue was fixed in Zamboni (must be between 12–24 hours) _____ hours	Date tissue placed in cryoprotectant <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Distal Leg <input type="checkbox"/> Mid Thigh <input type="checkbox"/> Dorsal Foot <input type="checkbox"/> Lower Abdomen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left		Time tissue placed in cryoprotectant  <input type="checkbox"/> am <input type="checkbox"/> pm
<b>Biopsy Site: 2</b>	<b>Body Side</b>	Amount of time tissue was fixed in Zamboni (must be between 12–24 hours) _____ hours	Date tissue placed in cryoprotectant <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Distal Leg <input type="checkbox"/> Mid Thigh <input type="checkbox"/> Dorsal Foot <input type="checkbox"/> Lower Abdomen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left		Time tissue placed in cryoprotectant  <input type="checkbox"/> am <input type="checkbox"/> pm
Tentative Clinical Diagnosis			
<b>Reminder: Include the following required information along with this form for a complete consultation.</b>			
<input type="checkbox"/> Neurology Clinical Notes <input type="checkbox"/> NCS/EMG results <input type="checkbox"/> NCS/EMG not performed			