DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE
University of Kentucky Chandler Medical Center
Histology Lab, 800 Rose Street, Room HL409
Lexington, KY 40536-0293

## DIVISION OF NEUROPATHOLOGY

## *Skeletal Muscle or Peripheral Nerve Evaluation Request*

*Biopsy should be scheduled with the lab at least 24 hrs in advance of procedure.*
*Inform Histology Lab of any special handling needs at that time. (859) 257-1822.*

**Submitting Facility Name**

Address________________________________
________________________________________

Phone ________________ Fax______________

*(check one)*

- ☐ **Medicare In-patient**
- ☐ **Inpatient with insurance** ***(include copy of insurance card)***
- ☐ **Outpatient with insurance** ***(include copy of insurance card)***

**Submitting Physician/Surgeon name**

________________________________________

Phone ________________ Fax______________

**Neurologist or Primary Physician requesting biopsy**

________________________________________

Phone ________________ Fax______________

# Patient Information

**ICD-9 code or reason for medical necessity of this procedure**

________________________________________

**Patient Name**________________________
Date of Birth__________________________
Social Security #_______________________

*(circle one)*
Sex Male / Female

**Brief clinical summary and duration of symptoms:**

**Neurophysiologic studies (EMG/NCV) compatible with** : ________________________________

**Suspect metabolic disorder ?** **YES / NO**
*(If a metabolic disorder is suspected, the surgeon should submit snap frozen fresh tissue for enzymatic analysis.)*

**Muscle(s) biopsied:***(circle one)* **Biceps** **Deltoid** **Gastrocnemius** **Vastus Lateralis** **Other**

**Tissue specimens submitted to Pathology include the following:** *(circle all that apply)*

| Fresh tissue | Formalin Fixed | Glutaraldehyde Fixed | Snap Frozen Fresh |
|---|---|---|---|
| (routine) | (routine) | (for EM) | (for enzyme analysis) |

**Photocopy this form upon completion of information and send copies to:**

**Original**: to the Histology Lab, Department of Pathology, Room HL 409
**Fax:** to the Neuropathology Lab, 859.257.5074
**Copy:** to the Surgeon, neurologist, or primary care physician