



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 _____

Submitting Physician/Surgeon name

Phone _____ Fax _____

Neurologist or Primary Physician requesting biopsy

Phone _____ Fax _____

(check one)

Medicare In-patient

Inpatient with insurance

(include copy of insurance card)

Outpatient with insurance

(include copy of insurance card)

Patient Information

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

Patient Name _____

Date of Birth _____

(circle one)

Social Security # _____

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 (routine)

Formalin Fixed (routine)

Glutaraldehyde Fixed (for EM)

Snap Frozen Fresh (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