Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

MUSCLE/NERVE SURGICAL REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

DIAGNOSIS CODE (REQUIRED) ICD-9 Codes: 1. _____ 2. _____ 3. _____

CLINICAL INFORMATION (COMPLETE BELOW OR ATTACH CLINICAL NOTE)

Clinical Diagnosis:

Brief Medical History (distribution of weakness, sensory loss, reflex change):

Past Medical History (diabetes, collagen vascular disease, metabolic disease, familial neuropathies, neoplasms, trauma):

EMG / NCS:

Drug Therapy (current medications, previous medications with immunosuppressive, myotoxic, or neurotoxic effects with date discontinued):

Previous Biopsy: ☐ No ☐ Yes (if Yes, when and where?): _____

Laboratory Data: Provide below or attach applicable laboratory results

CPK	**Aldolase**
ESR	**ANF**

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

SPECIMEN INFORMATION

Please indicate number of tubes, vials, slides, tissue blocks provided

Collection Date: _____/_____/_____ Time: _____

☐ Muscle Biopsy

Site(s): _____ ☐ Left ☐ Right

☐ Nerve Biopsy

Site(s): _____ ☐ Left ☐ Right

Specimen Type (see Information Sheet and check all that apply):

☐ Fresh Unfrozen Tissue (preferred for muscle)
☐ Formalin Fixed
☐ Glutaraldehyde
☐ Other: _____

SURGICAL PATHOLOGY SERVICES REQUESTED:

☐ **Muscle Biopsy Evaluation**
Routine evaluation includes H&E and enzyme histochemistry. Electron microscopy and IHC for dystrophy-associated antigens will be performed at the discretion of the neuromuscular pathologist.

☐ **Nerve Biopsy Evaluation**
Routine evaluation includes H&E, special stains, and examination of resin-embedded sections. Electron microscopy will be performed at the discretion of the neuromuscular pathologist.

☐ Additional Testing (specify): _____

Treating physician name

Treating physician phone number

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