

PHYSICIAN ORDER FOR MUSCLE/NERVE/SKIN BIOPSY SURGERY

REQUEST FORM FOR BIOPSIES TO BE PERFORMED AT UAB

To: _____ FAX#: _____ From: _____

The Shin J. Oh Muscle and Nerve Histopathology Laboratory at UAB

BIOPSY REQUISITION

1720 7th Avenue South, SC 427

Birmingham, AL 35233

Phone: 205-934-2127 • Fax: 205-975-4457

Patient name: _____ Date of birth/MRN: _____

Telephone number(s): _____

Clinical diagnosis/indications: _____

Please include CK if it is known. **Attach EMG report or other pertinent information.

Is this patient on steroids, immunosuppressants, or statins? YES NO

If yes, please list: _____

Please instruct patient to discontinue aspirin or other blood-thinning agents(s) 3 to 4 days before biopsy is to be performed, if medically advisable.

Please circle:

Muscle to be biopsied: Left or Right Bicep/deltoid/anterior tibialis/vastus lateralis/other _____

Nerve to be biopsied: Left or Right Sural

Skin to be biopsied: Left or Right Ankle and thigh

Name of ordering physician: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Emergency physician contact information, in the event additional information is required on day of biopsy:

Emergency contact name: _____ Phone: _____

Signature of ordering physician: _____

****PLEASE NOTE—BIOPSY WILL NOT BE SCHEDULED UNTIL THIS COMPLETED FORM IS RECEIVED.**