MC900055181[1]

University of Arkansas for Medical Sciences

**Neuropathology Division**

Department of Pathology

Room S4/22 Shorey Building

4301 West Markham Street

Little Rock, AR 72205

(501) 526-4918 (Lab—Allison Theus)

**Muscle / Nerve Biopsy Request Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ M 􀂉 F

􀂉 Muscle biopsy 􀂉 Nerve biopsy Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Patient # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Facility Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Requesting Facility Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_ FAX reports to: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical history, differential diagnosis, special requests:

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Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

(Must be legible and cannot be stamped.)

Physician’s Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 12-06-2010