Indiana University Health

IU Health Pathology Laboratory
350 W. 11th Street
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740

Patient Legal Name (Last, First M I)	Date/Time of Collection
Gender (at Birth) M F	DOB
Address	SSN / MRN
City, State, Zip	Telephone Number
Print Physician's Name (F, MI, L)	Diagnosis
Physicians Signature	ICD-10 Diagnosis Codes:
Client:	☐ BILL FACILITY ☐ BILL PATIENT OR INSURANCE ☐ SPLIT BILL: TC TO FACILITY & PC TO INSURANCE (Medicare, Medicaid, Tricare) **NOTE: For split and patient bill: Attach Face Sheet & Insurance Card**

MUSCLE / PERIPHERAL NERVE BIOPSY REQUISITION

DO NOT PLACE IN FORMALIN

Tissue sent: ☐ Fresh ☐ Flash Frozen

Biopsy Site: _____

Symptoms Duration:

Weakness Distribution:

Relevant Family History:

Prior Biopsies / Additional Information:

Current Medications:

Exposure to Corticosteroids in the past 3 months. (List Dose and Dates)

Please include a Neurology Initial Evaluation (or Rheumatology Evaluation). Include EMG report if available.

Date of EMG ___/___/_____

Results: