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STRONG HEALTH

Strong Memorial Hospital • Golisano Children's Hospital at Strong • Highland Hospital
The Highlands • Eastman Dental Center • Visiting Nurse Service

# BIOPSY REQUEST FORM

**Neuromuscular Laboratory: (585) 275-1330**
**Biopsy Scheduling Office: (585) 275-6372; Fax: (585) 273-1255**

Patient's Name: _____ EMRN: _____
Address: _____ DOB: _____
_____ Phone: _____
Insurance Info: _____ Referral #: _____

**Type of Biopsy:**

**Muscle:** ☐ Needle ☐ Open **Location:** ☐ Right ☐ Left
**Muscle:** _____

**Nerve:** ☐ Sup. Peroneal ☐ Sural **Location:** ☐ Right ☐ Left

**Skin:** ☐ **Location:** ☐ Right ☐ Left

Collect Samples for: ☒ Histology ☐ Formalin ☐ Biochemistry ☐ E.M ☐ PLP

Special Stains: ☐ MAD, PHOS, PFK ☐ PGP 9.5 ☐ Dystrophins, Adhalin, Merosin ☐ Amyloid

Differential Diagnosis: _____

_____

Current Medications: _____

Is patient taking **Coumadin**? ☐ Yes ☐ No **Lovanox**? ☐ Yes ☐ No

Does the patient have any known allergies? ☐ Yes ☐ No If yes, allergic to: _____

Does the patient require antibiotic prophylaxis? ☐ Yes ☐ No

Abnormal labs: _____

History: _____

_____

Known Infection Risks (HIV, Hepatitis, etc.): _____

Referring MD: _____ Phone: _____

Address: _____ Fax: _____

_____ _____

***Referring Physician's Signature***: _____

***Note:*** *Biopsy Request Form MUST be signed by referring MD and received by the Neuromuscular Disease Center at least 24 hours BEFORE the biopsy. Fax (2-pages) to: (585) 273-1255, ATTN: Eileen.*

## ** Please Complete and Sign Page 1; Optional: Page 2 **

## *Send the tissue sample for the following tests:*

☐ **Children's Hospital, Buffalo NY**

☐ Mitochondrial Myopathy Screen

☐ Metabolic Myopathy, specify enzyme to be tested: _____

_____

☐ **Athena Diagnostics**
Dystrophin Western Blot: _____

_____

☐ **University of Iowa**
Limb Girdle dystrophy screen, specify type to be tested: _____

_____

☐ **Other:** Specify lab and test to be performed: _____

_____

_____

***Referring Physician's Signature***: _____

**FOR NEUROMUSCULAR CENTER OFFICE USE ONLY**

Appointment Date: _____ Time: _____ AM/PM Directions/Letter Sent: _____
Physician doing procedure: _____ Entered in IDX: _____
Other Action: _____ AC-2 or ID Tag: _____