AUSTIN NEUROMUSCULAR CENTER

CAP#:8239200
CLIA#:45D2114599

## PATIENT & ORDERING PHYSICIAN/FACILITY INFORMATION

PATIENT NAME

DATE OF BIRTH

STREET ADDRESS

CITY, STATE, ZIP

TELEPHONE

☐ MALE ☐FEMALE

ORDERING PHYSICIAN/NPI#

FACILITY

STREET ADDRESS

ROOM NUMBER

CITY, STATE, ZIP

PHONE FAX

## PATIENT INSURANCE INFORMATION (Complete below AND attach a copy of the insurance card[s], front and back.)

PRIMARY INSURANCE

ID/SUBSCRIBER/POLICY

GROUP

INSURED'S NAME

INSURED'S DOB

RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

ID/SUBSCRIBER/POLICY NO.

GROUP NO.

INSURED'S NAME

INSURED'S DOB

RELATIONSHIP TO PATIENT

## CLINICAL INFORMATION (Complete below AND attach a copy of records, clinical history and exam, lab and test results.)

☐ **DIAGNOSIS CODES (ICD 10):**

☐ **ATTACH CLINICAL HISTORY AND EXAM, INDICATIONS, LAB AND TEST RESULTS**

## TEST SELECTION

☐ **SKIN BIOPSY/SMALL FIBER NEUROPATHY EVALUATION ROUTINE PANEL**
Frozen Sections: *H&E, PGP 9.5, Congo Red, CD3*

☐ **SKELETAL MUSCLE BIOPSY ROUTINE PANEL**
*H&E x 2, NADH, GT, ATPase pH 9.4, 4.6 and 4.3, Congo Red, Sudan Black, Alkaline Phosphatase, Esterase, Periodic Acid Schiff (PAS), Cytochrome Oxidase, Succinic Dehydrogenase, Phosphorylase, AMPDA, Morphometry*

☐ **PERIPHERAL NERVE BIOPSY ROUTINE PANEL**
Frozen Sections: *H&E, GT, Congo Red, Alkaline Phosphatase, Esterase, and teased nerve*

☐ **IMMUNE MYOPATHY / NEUROPATHY ROUTINE PANEL**
*MHC Class I, C5b-9 (MAC), CD3*

☐ **DYSTROPHY ROUTINE PANEL**
**Immunocytochemistry (IHC) or Western blot (WB) performed at Washington University Neuromuscular Lab.**
*Dystrophin (4 epitopes); Sarcoglycans (α, β, γ, δ ); Desmin; Emerin; Caveolin-3; Laminin-α2; α-Dystroglycan; Dysferlin; Phalloidin; LAMP2*

☐ **BIOCHEMISTRY**
**EXTRA SPECIMEN MAY BE REQUIRED (> 0.5 $cm^3$, 100 mg); performed at Washington University Neuromuscular Lab.**
☐Mitochondrial oxidative enzymes ☐Glycogen pathways

## BIOPSY LOCATION (Depth: minimum size 3mm)

| | | | | |
|---|---|---|---|---|
| **SKIN** | **A (ankle)** | **10 cm proximal to lateral malleolus (calf)** | ☐ **Right** | ☐ **Left** |
| | **T (thigh)** | **10 cm proximal to lateral patella (thigh)** | ☐ **Right** | ☐ **Left** |
| **MUSCLE** | **Site:**_______________ | | ☐ **Right** | ☐ **Left** |
| **NERVE** | **Site:**_______________ | | ☐ **Right** | ☐ **Left** |

## SPECIMEN COLLECTION

**DATE:** _______________ **TIME:**_______________ ☐ **AM** ☐ **PM**

## INSTRUCTIONS

☐ Affix enclosed **labels on vials** with patient name, date of birth, collection site, date and time. Insert into an enclosed biohazard bag.

☐ Place this **Requisition Form (and copy of insurance card, records, clinicals, history, exams, lab and test results) with specimens** in white envelope.

☐ **Call FedEx to arrange same day pick-up Mon-Thurs only with standard overnight delivery**. **NO WEEKEND DELIVERY.**

## AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

I consent to have testing services performed by Austin Neuromuscular Center on my sample. I hereby authorize and request that my insurer pay any benefits due for these services directly to Austin Neuromuscular Center. I authorize Austin Neuromuscular Center to provide my insurer with all of the necessary information, including test results, that is needed to receive payment for these tests. I further authorize my insurer to provide Austin Neuromuscular Service with all pertinent information concerning coverage, payments, appeals and grievances. I agree to submit within 15 days, to Austin Neuromuscular Center, any payments for these services that were made directly to me. **I authorize Austin Neuromuscular Center to file any appeal, grievance or claim review to my insurance carrier on my behalf.**

I agree to be personally and fully responsible for any portion of the claim not covered by my insurer and agree to make such payment to Austin Neuromuscular Center within 30 days of receiving notice. A service charge of 1.5% per month may be charged on balances over 30 days. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default. I further agree and acknowledge that any court action between Austin Neuromuscular Center and myself, including, but not limited to, issues relating to payment shall be brought in a court of appropriate jurisdiction in Travis County, Texas. Austin Neuromuscular may, at its sole discretion, choose to bring any such action in the jurisdiction in which I reside.

_______________________________ _______________________________

**Signature of Patient (or person authorized to sign for the patient)** **Date**