AUSTIN NEUROMUSCULAR CENTER

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS
CAP#8239200

Clinical Laboratory Improvement Amendments CLIA Certified
CLIA#45D2114599

# PATHOLOGY LAB REQUISITION FORM

## PATIENT, ORDERING PHYSICIAN & FACILITY INFORMATION

| | |
|---|---|
| Patient Name | Ordering Physician/NP# |
| Date Of Birth | Facility Name |
| Street Address | Street Address |
| City, State, Zip | City, State, Zip |
| Phone ☐ Home ☐ Cell | Room/Suite |
| Gender ☐ Female ☐ Male | Phone Fax |

## PATIENT INSURANCE INFORMATION (Complete all information AND attach copy of insurance card(s)-front and back)

| | |
|---|---|
| Primary Insurance | Secondary Insurance |
| ID/Subscriber/Policy # | ID/Subscriber/Policy # |
| Group # | Group # |
| Insured's Name | Insured's Name |
| Insured's Date of Birth | Insured's Date of Birth |
| Relationship To Patient | Relationship To Patient |

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

☐ Diagnosis Codes (ICD 10)

☐ Attach Clinical records, clinical history, exams, lab, and test results

## TEST TO CONDUCT

| | |
|---|---|
| ☐ **SKIN BIOPSY/SMALL FIBER NEUROPATHY EVAL ROUTINE PANEL**<br>*Frozen Sections: H&E, PGP 9.5, Congo Red, CD3* | ☐ **IMMUNE MYOPATHY / NEUROPATHY ROUTINE PANEL**<br>*MHC Class I, C5b-9 (MAC), CD3* |
| ☐ **SKELETAL MUSCLE BIOPSY ROUTINE PANEL**<br>*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* | ☐ **DYSTROPHY ROUTINE PANEL**<br>**Immunocytochemistry (IHC) or Western blot (WB) performed at Washington University Neuromuscular Lab**<br>*Dystrophin (4 epitopes); Sarcoglycans (α, β, γ, δ ); Desmin; Emerin; Caveolin-3; Laminin-α2; α-Dystroglycan; Dysferlin; Phalloidin; LAMP2* |
| ☐ **PERIPHERAL NERVE BIOPSY ROUTINE PANEL**<br>Frozen Sections: *H&E, GT, Congo Red, Alkaline Phosphatase, Esterase, and teased nerve* | ☐ **BIOCHEMISTRY-EXTRA SPECIMEN MAY BE REQUIRED (> 0.5 $cm^3$, 100 mg); performed at Washington University. Neuromuscular Lab**<br>☐ **Mitochondrial Oxidative Enzymes** ☐ **Glycogen Pathways** |

## BIOPSY LOCATION

| | | | |
|---|---|---|---|
| SKIN | A (Ankle)10 cm proximal to the lateral malleolus (calf) | ☐ Right | ☐ Left |
| | T (Thigh) 10 cm proximal to the lateral patella (thigh) | ☐ Right | ☐ Left |
| MUSCLE | Site: | ☐ Right | ☐ Left |
| NERVE | Site: | ☐ Right | ☐ Left |

## SPECIMEN COLLECTION

| | |
|---|---|
| **DATE:** | **TIME:** ☐ **AM** ☐ **PM** |

## INSTRUCTIONS CHECKLIST (Make sure you follow all instructions)

☐ Affix enclosed labels on vials with the patient's name, date of birth, collection site, date, and time

☐ Insert labeled vials in the biohazard bag

☐ Place this Requisition Form along w/copy of insurance card(s) (front & back), records, clinicals, exams, lab, test results, and specimens in the white envelope

☐ Ship via FedEx for Monday-Thursday same-day pickup ONLY with standard overnight delivery. NO WEEKEND DELIVERY.

## CONSENT TO TEST & AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

I consent to have testing services performed by Austin Neuromuscular Center **"ANC"** on my sample. I hereby authorize and request that my insurer pay any benefits due for these services directly to **ANC**. I authorize **ANC** to provide my insurer with all the necessary information needed to receive payment for these tests, including test results. I further authorize my insurer to provide **ANC** with all pertinent information concerning coverage, payments, appeals, and grievances. I agree to submit within 15 days, to **ANC**, any payments for these services that were made directly to me. **I authorize ANC 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 **ANC** within 30 days of receiving notice. A service charge of 1.5% per month may be charged on balances over 30 days. If I default on the 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 **ANC** and myself, including, but not limited to, issues relating to the payment shall be brought in a court of appropriate jurisdiction in Travis County, Texas. **ANC** may, at its sole discretion, choose to bring any such action in the jurisdiction in which I reside.

Signature of Patient or Authorized Representative Date