URMC LABS
DEPT. OF PATHOLOGY AND LABORATORY MEDICINE

# Specimens:		
Collect Date:	Time:	By:
MR #:	A #:	

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Social Security Number

Street Address

City, State, Zip

Phone Number | Client Number

Indicate primary (1) and secondary (2) insurance

__Blue Cross/Shield __Child Health Plus __Preferred Care
__Blue Choice __Medicaid __Preferred Care Gold
__Blue Choice Senior __Medicare __Aetna
__Other _____

1. Primary Contract #: _____
Subscriber's Name: _____
Relationship to Subscriber: _____
2. Secondary Contract # _____
Subscriber's Name: _____
Relationship to Subscriber:

Phone Results to: Fax Results to:

Ordering Provider's Signature

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

NEUROMUSCULAR SPECIMENS

Biopsy Date:

Collection Time:

BIOPSY SITE (DESCRIBE SITE OF BIOPSY PRECISELY):

TYPE OF BIOPSY

- ☐ Muscle
- ☐ Nerve
- ☐ Skin

RELEVANT CLINICAL HISTORY (REQUIRED)
DIFFERENTIAL DIAGNOSIS/SPECIFIC QUESTIONS/LAB TESTS:

- ☐ See Attached Reports
- ☐ CD Rom
- ☐ Wet Tissue
- ☐ Blocks
- ☐ Slides

Known Infection Risks (HIV, Hepatitis, etc):

Tissue Sent:

- ☐ Formalin
- ☐ Glutaraldehyde
- ☐ Frozen
- ☐ PLP

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