PHYSICIAN ORDER FOR MUSCLE/NERVE/SKIN BIOPSY SURGERY

REQUEST FORM FOR BIOPSIES TO BE PERFORMED AT UAB

To: _____ FAX#: _____ From: _____

The Shin J. Oh Muscle and Nerve Histopathology Laboratory at UAB
BIOPSY REQUISITION
1720 7th Avenue South SC 427
Birmingham, AL 35233
Phone: 205-934-2127 • Fax: 205-975-4457

Patient name: _____ Date of Birth/MRN: _____

Telephone number(s): _____

Clinical diagnosis/indications: _____

Please include CK if it is known. **Attach EMG report or other pertinent information.

Is this patient on steroids, immunosuppressant's, or statins? ☐ YES ☐ NO

If yes, please list: _____

Please instruct patient to discontinue aspirin or other blood-thinning agents(s) 3 to 4 days before biopsy is to be performed if medically advisable.

Please circle:

Muscle to be biopsied: Left or Right Bicep/Deltoid/Anterior Tibialis/Vastus Lateralis/Other _____

Nerve to be biopsied: Left or Right Sural

Skin to be biopsied: Left or Right Ankle and Thigh

Name of ordering physician: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Emergency physician contact information in the event additional information is required on day of biopsy:

Emergency Contact Name: _____ Phone: _____

Signature of ordering physician: _____

****PLEASE NOTE—BIOPSY WILL NOT BE SCHEDULED UNTIL THIS COMPLETED FORM IS RECEIVED.**

UAB MEDICINE