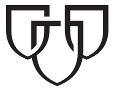

MAYO CLINIC LABORATORIES

Muscle Histochemistry Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Neurologist or Rheumatologist Name *(Last, First)*	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Send Reports To

Name		Fax Number (only if fax is preferred)	
Street Address	City	State	ZIP Code

If additional reports are needed, include address below.

Name		Fax Number (only if fax is preferred)	
Address	City	State	ZIP Code

Clinical Information **To prevent delays and enhance accuracy of the interpretation, all information below must be provided.**

Biopsied Muscle Name (be specific)	Surgery Date *(mm-dd-yyyy)*
Is Tissue Infectious ☐ Yes ☐ No	Freezing Method ☐ Isopentane chilled by liquid nitrogen (preferred) ☐ Dry ice/acetone slurry ☐ Dry ice/alcohol slurry
Clinical Diagnosis	
Symptoms Duration (days/weeks/months/years)	
Weakness Distribution	
Relevant Family History	
Other Associated Symptoms	

Note: Include a Neurology Initial Evaluation (or Rheumatology Evaluation if Neurology is not available.) Include electromyogram (EMG) report if available. **Surgical notes are not acceptable.**

EMG Results	Current Medications	Laboratory Findings (*required information)
Performed ☐ Yes ☐ No Date Performed *(mm-dd-yyyy)*: ____________________ Results	Exposure to Corticosteroids in past 3 months (list dose and dates)	*CK ____________ AST ____________ LDH ____________ ESR ____________ ANA ____________ Rheumatoid Factor ____________ Other Relevant Laboratory Findings

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