Please complete, print and submit. Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Bone Histomorphometry: Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(Month DD, YYYY)*	Gender ☐ Male ☐ Female
Requesting Physician *(Last, First)*	Phone	Fax*
Phone Consultation (Name):		Phone
Report Sent To (Name):	Address (Street, City, State, Zip	

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

Clinical Information (required)

Surgery Date *(Month DD, YYYY)*	Surgeon *(Last Name, First Name)*
Biopsy Site	Has a biopsy been previously submitted? ☐ Yes ☐ No
Clinical Diagnosis/Indications for Biopsy	
Pertinent History	

Tetracycline

Provide specific dates of tetracycline administration.

First Label: Drug Name		Second Label: Drug Name	
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose

MML Use Only

Accession Number

Print