MAYO CLINIC
Mayo Medical Laboratories

Electron Microscopy Patient Information

Instructions: To help provide the best possible service, please supply the information requested below and send paperwork with the specimen.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(Month DD, YYYY)*	Gender ☐ Male ☐ Female
Referring Physician *(Last, First)*	Phone	Fax
Pathologist Name *(Last, First)*	Phone	Fax

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

Reason for Testing

☐ Bullous disease
☐ CADASIL
☐ Ciliary morphology
☐ Connective tissue disorder-specify _____
☐ Microvillous inclusion disorder
☐ Mitochondrial disorder-specify _____
☐ Storage disease-specify _____
☐ Tumor-specify _____
☐ Viral inclusion
☐ Other _____

Patient History/Pathologist Comments

Specimen Fixative

☐ Trumps fixative	☐ 2.5% - 3% Glutaraldehyde	☐ Other *(call lab before submitting)*

Specimen type

☐ Skin ☐ Whole Blood ☐ Ciliary Brushing ☐ Buffy Coat ☐ Nasal ☐ Liver ☐ Trachea ☐ Duodenum ☐ Heart
☐ Other_____