MAYO CLINIC
Mayo Medical Laboratories

Epidermal Nerve Fiber Density Patient Information Sheet

Instructions: To help provide the best possible service, supply the requested information below and **send this paperwork with the specimens.**

Patient Name *(Last Name, First Name, Middle Initial)*		Birth Date *(Month DD, YYYY)*	Sex ☐ Male ☐ Female
Referring Neurologist	Phone	Fax	
Neurologist Address	City	State	ZIP Code

Send Report to:

All results will be faxed and mailed. Complete all information below to indicate where report should be sent.

Name of Hospital/Clinic Sending Biopsy		MML Account Number (if known)	
Address	City	State	ZIP Code
Attention	Phone	Fax	

Clinical Information

All information below is required. Specimens will not be processed if information is not completed.
Two 3 mm skin punch biopsies required
Use only fixative, buffer, and cryoprotectant provided in the kit by Mayo Medical Laboratories.

Name of Tissue *(example – 3mm skin punch)*			Procedure Date *(Month DD, YYYY)*
Biopsy Site: **Distal Leg**	Side of Body ☐ Right ☐ Left	Amount of time tissue was fixed in PLP (must be between 12-24 hours) _____hours	Date and Time tissue placed in cryoprotectant _____date _____time
Biopsy Site: **Mid Thigh**	Side of Body ☐ Right ☐ Left	Amount of time tissue was fixed in PLP (must be between 12-24 hours) _____hours	Date and Time tissue placed in cryoprotectant _____date _____time
Tentative Clinical Diagnosis			

Reminder: Include the following required information along with this form for a complete consultation.

☐ Neurology Clinical Notes

☐ NCS/EMG results ☐ NCS/EMG not performed

Part 1 - (white original) MML • Part 2 - (yellow copy) Client

MML Supply T702
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