Please complete, print and submit. Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Electron Microscopy Technical Only Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(Month DD, YYYY)*	Gender ☐ Male ☐ Female
Requesting Physician Name *(Last, First)*	Phone	Fax
Requesting Physician Email	Patient Medical Record Number (MRN)	

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

Reason for Testing

☐ Renal Pathology (differential diagnosis)

☐ Storage Disease (specify) _____

☐ Ciliary Morphology

☐ CADASIL

☐ Tumor (differential diagnosis) _____

☐ Microvillous Inclusion Disorder

☐ Other _____

Patient History/Pathologist Comments

Specimen Type

☐ Fixed Wet Tissue (check fixative used) ☐ Trumps ☐ 2.5%-3% Glutaraldehyde ☐ Other _____

☐ Resin Blocks

☐ Grids

Specimen/Sample ID (identifier to be used on digital image label)

Tissue Source

☐ Kidney	☐ Cilia	☐ Liver	☐ Skin
☐ Duodenum	☐ Heart	☐ Other _____	