MAYO
Mayo Medical Laboratories

Muscle Histochemistry Patient Information Sheet

Patient Information:

Patient Name – Last Name	First Name	Middle Initial	Birth Date *(Month DD, YYYY)*	Sex

Referring Neurologist or Rheumatologist	Phone Number

MML Client Account Number (if known)

Send Reports to: (if additional reports are needed, please include address on reverse side of this form.)

Name	If fax is preferred indicate Fax Number	
Street Address	If 2nd report requested, indicate additional fax number	
City	State	ZIP Code

Clinical Information – Results may be delayed if information below is not provided

Muscle Name	Surgery Date *(Month 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

Duration of Symptoms *(days/weeks/months/years)*

Distribution of weakness

Relevant family history

Other associated symptoms

NOTE: Please include a Neurology Initial Evaluation (or Rheumatology Evaluation if Neurology is not available.) Include EMG report if available.
Surgical notes are not acceptable.

Electromyogram (EMG) Results
Performed ☐ Yes ☐ No
Date Performed
_____

Results
_____
_____
_____
_____
_____
_____
_____

Current Medications
_____
_____
_____
_____
_____

Exposure to Corticosteroids
in past 3 months (list dose and dates)
_____
_____

Laboratory Findings (*required information)
*CK: _____
AST: _____
LDH: _____
ESR: _____
ANA: _____
Rheumatoid Factor: _____

Other relevant laboratory findings
_____
_____