MAYO CLINIC
Mayo Medical Laboratories

Nerve Biopsy Information Sheet

ALL information below must be completed.
A copy of the Neurology Clinical Notes and EMG results are also required for testing.

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

Reporting:

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

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

Additional Reports: Complete information below if additional report is wanted.

Facility Name or Person to receive report	Phone	Fax*	
Address	City	State	ZIP Code

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

Biopsy Information

Name of Nerve Biopsied *(Example – Left Sural Nerve, Whole, Ankle)*		Surgery Date *(Month DD, YYYY)*
If a MML Nerve Biopsy Kit is not used, include fixatives and buffers used	**Segment A:** Fixative	Buffer
	Segment B: Fixative	Buffer

Clinical Information

Tentative Clinical Diagnosis
Indication for Nerve Biopsy

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

MML Supply T458
MC1235-90rev1008