Arkana Laboratories

Electron Microscopy Requisition Form

Affix patient sticker here

Collection Date: _____

Biopsy Type: ☐ Renal ☐ Transplant / ☐ Native ☐ Muscle ☐ Nerve ☐ Other

Surgical Number: _____ **Specimen(s) identification:** _____

Reasons to perform EM: _____ **IDC 9/10**: _____

Requested testing:

☐ EM Thicks (CPT 88323 + TC-88313_)

☐ EM Thicks & Ultrastructural Imaging (CPT TC-88348)

☐ Full EM Consultation (CPT 88348)

Patient Information:

Patient Name: _____ Date of Birth (MMDDYYYY): _____ Gender: ☐ M ☐ F

Referring Physician:

Physician: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email address: _____

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