Arkana Laboratories

Electron Microscopy Requisition Form

Affix patient sticker here

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: _____

10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com
arkanalabs.com

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