Muscle & Nerve Biopsy Requisition Form

Arkana Laboratories

Affix patient sticker here

Patient Information:

Patient Name: _____ Social Security #: _____ Gender: ☐ M ☐ F

Date of Birth (MMDDYYYY): _____ Phone #: _____ Marital Status: ☐ Married ☐ Single ☐ Other

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

Spouse Name: _____ Social Security #: _____ Date of Birth (MMDDYYYY): _____

Clinical Information:

Surgical Number: _____ Biopsy site: _____ Biopsy Date: _____

Working/suspected clinical diagnosis/differential: _____

Clinical history, patient pertinent current and prior history, and pertinent physical exam findings *attach additional sheets as needed*: _____

_____

Lab Studies: ☐ Serum markers (CPK, Auto-antibodies, Aldolase, Other) ☐ EMG/NCV ☐ Other

Family history: _____

Medications:

☐ Steroid (current or prior treatment with steroid [indicate date of last dose if discontinued]) Date: _____ ☐ Chloroquine/hydroxychloroquine

☐ Cholesterol lowering drug (please provide specific drug name(s) if known) Date: _____ ☐ Anti-retroviral (ex AZT or HAART)

Other medications: _____

Referring Physician:

Treating Physician; Neurologist, Rheumatologist, Internal Medicine (Required information) : _____

Phone #: _____ Fax #: _____

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

Surgeon performing biopsy: _____ Phone #: _____

Third-Party Billing Information: Complete or attach a copy of insurance card and authorization

Insured/Responsible Party: _____ Date of Birth (MMDDYYYY): _____ Gender: ☐ M ☐ F

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

Phone #: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Member ID #: _____ ☐ Medicare ☐ Medicaid ☐ HMO ☐ PPO ☐ Other

Policy #: _____ Group #: _____

Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone #: _____

Employer Name: _____ Employer Phone #: _____

Referral Authorization/Precertification #: _____

Print Name: _____ Signature: _____ Date: _____

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