

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Neurologist or Rheumatologist Name <i>(Last, First)</i>	Phone	Fax*

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

Send Reports To

Name		Fax Number (only if fax is preferred)	
Street Address	City	State	ZIP Code

If additional reports are needed, include address below.

Name		Fax Number (only if fax is preferred)	
Address	City	State	ZIP Code

Clinical Information To prevent delays and enhance accuracy of the interpretation, all information below must be provided.

Biopsied Muscle Name (be specific)		Surgery Date <i>(mm-dd-yyyy)</i>	
Is Tissue Infectious <input type="checkbox"/> Yes <input type="checkbox"/> No	Freezing Method <input type="checkbox"/> Isopentane chilled by liquid nitrogen (preferred) <input type="checkbox"/> Dry ice/acetone slurry <input type="checkbox"/> Dry ice/alcohol slurry		
Clinical Diagnosis			
Symptoms Duration (days/weeks/months/years)			
Weakness Distribution			
Relevant Family History			
Other Associated Symptoms			
Note: Include a Neurology Initial Evaluation (or Rheumatology Evaluation if Neurology is not available.) Include electromyogram (EMG) report if available. Surgical notes are not acceptable.			
EMG Results Performed <input type="checkbox"/> Yes <input type="checkbox"/> No Date Performed <i>(mm-dd-yyyy)</i> : _____	Current Medications		Laboratory Findings (*required information)
Results	Exposure to Corticosteroids in past 3 months (list dose and dates)		*CK _____
			AST _____
			LDH _____
			ESR _____
			ANA _____
			Rheumatoid Factor _____
			Other Relevant Laboratory Findings