

Electron Microscopy Patient Information Sheet

Instructions: To help provide the best possible service, please supply the information requested below and send paperwork with the specimen.

Patient Information

Patient Name <i>(Last, First, Middle)</i>		Birth Date <i>(Month DD, YYYY)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Physician Name	Phone	Fax	
Pathologist Name	Phone	Fax	

Send Report to

MML Account Number <i>(if known)</i>	Name of Hospital/Clinic Sending Specimen		
Street Address			
City	State	ZIP	
Attention	Phone	Fax	

Specimen Fixative

<input type="checkbox"/> Trumps fixative	<input type="checkbox"/> 2.5% - 3% Glutaraldehyde	<input type="checkbox"/> Other <i>(please call lab before submitting)</i>
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Specimen type

<input type="checkbox"/> Skin <input type="checkbox"/> Whole Blood <input type="checkbox"/> Ciliary Brushing <input type="checkbox"/> Buffy Coat <input type="checkbox"/> Nasal <input type="checkbox"/> Liver <input type="checkbox"/> Trachea <input type="checkbox"/> Duodenum <input type="checkbox"/> Heart <input type="checkbox"/> Other: _____

Reason for Referral/Patient History

<input type="checkbox"/> Bullous disease <input type="checkbox"/> CADASIL <input type="checkbox"/> Ciliary morphology <input type="checkbox"/> Connective tissue disorder - specify: _____ <input type="checkbox"/> Microvillous inclusion disorder <input type="checkbox"/> Other: _____	<input type="checkbox"/> Mitochondrial disorder - specify: _____ <input type="checkbox"/> Storage disease - specify: _____ <input type="checkbox"/> Tumor - specify: _____ <input type="checkbox"/> Viral inclusion
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