



PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____

Age: ____ DOB: _____ Sex: ____ Race: ____ Hospital Tel. #: _____

Name and Address of Hospital: _____

Date of Biopsy: _____ Site: (circle one) L R Muscle: Quad / Biceps

L R Nerve: Sural

L R Other: _____

All addresses and phone numbers are needed. *Please include all Dr's first names.*

Referring Physician's Name: _____

→ **NPI# (Required)** _____
(Unique physician's identifier number) Tel: _____

Fax: _____

Address: _____

Pathologist's Name: _____ Tel: _____

Fax: _____

Address: _____

Surgeon's Name: _____ Tel: _____

Fax: _____

Address: _____

CLINICAL DIAGNOSIS: (See sheet supplied) _____
For example: 359.9(Myopathy) or 356.4(Polyneuropathy) or 335.29(Motor Neuron Disease)

→ **Insurance information must be complete and pre-approval must be obtained by the referring physician before sending specimen to Baylor. Please include a photocopy of patients insurance.** Who will be the contact person if there are any questions regarding billing (including phone number)?

PLEASE ATTACH CLINICAL HISTORY and print the name and number of the person filling out this sheet.

→ **Name:** **Tel. Number:**