

# MUSCLE/NERVE SURGICAL REQUISITION

<<FORM\_ID>>

<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</p> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>PRIMARY:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) <b>ABN:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <hr/> <p><b>CLINICAL INFORMATION</b> (COMPLETE BELOW OR ATTACH CLINICAL NOTE)</p> <p>Clinical Diagnosis: MEDICAL HISTORY</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Cardiac disease</td> <td><input type="checkbox"/> Failure to thrive</td> <td><input type="checkbox"/> Respiratory difficulty</td> </tr> <tr> <td><input type="checkbox"/> CNS disease</td> <td><input type="checkbox"/> Hypotonic</td> <td><input type="checkbox"/> Weakness</td> </tr> <tr> <td><input type="checkbox"/> Contractures</td> <td><input type="checkbox"/> Muscle Pain</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> <p>Past Medical History (diabetes, collagen vascular disease, metabolic disease, familial neuropathies, neoplasms, trauma):</p>  <p>EMG Findings: <input type="checkbox"/> Myopathic <input type="checkbox"/> Neuropathic Nerve Conduction Study Findings:</p>  <p>Drug Therapy (current medications, previous medications with immunosuppressive, myotoxic, or neurotoxic effects with date discontinued):</p>  <p>Statins <input type="checkbox"/> No <input type="checkbox"/> Yes Elevated CK <input type="checkbox"/> No <input type="checkbox"/> Yes Previous Biopsy: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, when and where?): _____</p>	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Respiratory difficulty	<input type="checkbox"/> CNS disease	<input type="checkbox"/> Hypotonic	<input type="checkbox"/> Weakness	<input type="checkbox"/> Contractures	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Other _____	<p style="text-align: center;"><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <hr/> <p>Neurologist / Rheumatologist Name _____</p> <hr/> <p>Neurologist / Rheumatologist Email _____</p> <p><input type="checkbox"/> Submitting department phone: (_____) _____</p> <hr/> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p><b>SPECIMEN INFORMATION</b></p> <p>Please indicate number of tubes, vials, slides, tissue blocks provided</p> <p>Collection Date: ____/____/____ Time: _____</p> <p><input type="checkbox"/> Muscle Biopsy</p> <p>Site(s): _____ Left Right</p> <p>Routine evaluation includes H&amp;E and enzyme histochemistry. Electron microscopy and IHC for dystrophy-associated antigens will be performed at the discretion of the neuromuscular pathologist unless specifically requested.</p> <p><input type="checkbox"/> EM to look for _____</p> <p><input type="checkbox"/> IHC for muscular dystrophy</p> <p><input type="checkbox"/> Nerve Biopsy</p> <p>Site(s): _____ Left Right</p> <p>Routine evaluation includes H&amp;E, special stains, and examination of resin-embedded sections. Electron microscopy will be performed.</p> <p><b>Specimen Type (see Information Sheet and check all that apply):</b></p> <p><input type="checkbox"/> Fresh Unfrozen Tissue (preferred for muscle)</p> <p><input type="checkbox"/> Glutaraldehyde</p> <p><input type="checkbox"/> Other: _____</p>
<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Respiratory difficulty								
<input type="checkbox"/> CNS disease	<input type="checkbox"/> Hypotonic	<input type="checkbox"/> Weakness								
<input type="checkbox"/> Contractures	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Other _____								