Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

MUSCLE/NERVE SURGICAL REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

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.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

PRIMARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if Yes, please attach) **ABN:** ☐ No ☐ Yes

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____

CLINICAL INFORMATION (COMPLETE BELOW OR ATTACH CLINICAL NOTE)

Clinical Diagnosis: _____

MEDICAL HISTORY

☐ Cardiac disease ☐ Failure to thrive ☐ Respiratory difficulty
☐ CNS disease ☐ Hypotonic ☐ Weakness
☐ Contractures ☐ Muscle Pain ☐ Other _____

Past Medical History (diabetes, collagen vascular disease, metabolic disease, familial neuropathies, neoplasms, trauma):

EMG Findings: ☐ Myopathic ☐ Neuropathic
Nerve Conduction Study Findings:

Drug Therapy (current medications, previous medications with immunosuppressive, myotoxic, or neurotoxic effects with date discontinued):

Statins ☐ No ☐ Yes
Elevated CK ☐ No ☐ Yes
Previous Biopsy: ☐ No ☐ Yes (if Yes, when and where?): _____

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

Neurologist / Rheumatologist Name

Neurologist / Rheumatologist Email

☐ Submitting department phone: (_____) _____

☐ Fax report to: (_____) _____

SPECIMEN INFORMATION

Please indicate number of tubes, vials, slides, tissue blocks provided

Collection Date: _____/_____/_____ Time: _____

☐ Muscle Biopsy

Site(s): _____ ☐ Left ☐ Right

Routine evaluation includes H&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.

☐ EM to look for _____
☐ IHC for muscular dystropy

☐ Nerve Biopsy

Site(s): _____ ☐ Left ☐ Right

Routine evaluation includes H&E, special stains, and examination of resin-embedded sections. Electron microscopy will be performed.

Specimen Type (see Information Sheet and check all that apply):

☐ Fresh Unfrozen Tissue (preferred for muscle)
☐ Glutaraldehyde
☐ Other: _____

Additional Tests

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

*CPT codes available online at clevelandcliniclabs.com 12/2023

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