

Muscle Histochemistry Patient Information Sheet

Patient Information:

Patient Name – Last Name	First Name	Middle Initial	Birth Date (Month DD, YYYY)	Sex
Referring Neurologist or Rheumatologist			Phone Number	
MML Client Account Number (if known)				

Send Reports to: (if additional reports are needed, please include address on reverse side of this form.)

Name	If fax is preferred indicate Fax Number		
Street Address	If 2nd report requested, indicate additional fax number		
City	State	ZIP Code	

Clinical Information – Results may be delayed if information below is not provided

Muscle Name	Surgery Date (Month DD, YYYY)
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	
Duration of Symptoms (days/weeks/months/years)	
Distribution of weakness	
Relevant family history	
Other associated symptoms	
NOTE: Please include a Neurology Initial Evaluation (or Rheumatology Evaluation if Neurology is not available.) Include EMG report if available. Surgical notes are not acceptable.	

Electromyogram (EMG) Results Performed <input type="checkbox"/> Yes <input type="checkbox"/> No Date Performed _____ Results _____ _____ _____ _____ _____ _____	Current Medications _____ _____ _____ _____	Laboratory Findings (*required information) *CK: _____ AST: _____ LDH: _____ ESR: _____ ANA: _____ Rheumatoid Factor: _____
	Exposure to Corticosteroids in past 3 months (list dose and dates) _____ _____	Other relevant laboratory findings _____ _____