EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Neurology – Neuromuscular Laboratory
101 Woodruff Circle, Room 6310 (WMB), Atlanta, GA 30322
404-727-3507 **office** / 404-727-3340 **lab** / 404-778-3495 **fax**
neurology.als.fax@emoryhealthcare.org **email**

Biopsy Information Sheet

Pt Name: ______________________________________ DOB __________________ Sex _______

Date of Biopsy: ____________ Site of Biopsy: _____________________ Your ID#: _____________

Surgeon: _______________________________

Office #: ______________________________

Fax #: ________________________________
(or email)

Address: ______________________________

____

Neurologist: ____________________________
(or Referring Physician)

Office #: ______________________________

Fax #: ________________________________
(or email)

Address: ______________________________

____

IT IS IMPORTANT TO INCLUDE AS MUCH OF THE FOLLOWING CLINICAL INFORMATION AS POSSIBLE

Brief Clinical History (please attach clinic note if available):

____

____

____

Diagnostic Considerations: ____

EMG Findings / Date (please attach report if available): __________________________

____

CK Levels / Date: _____________________________________ Diagnosis Code: ________________

Comments: ____

Submitted by: __________________________________ Phone #: ___________________________

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Billing Information

The facility sending the biopsy sample is primarily responsible for the payment of the biopsy charges. We do not bill the patient or their insurance carrier.

Primary Responsible Party (facility sending sample):

Hospital / Doctor's Office / Laboratory

Facility Name: ______________________________

Address: ______________________________ Phone #: ______________________________

______________________________ Fax #: ______________________________

Printed Name: ______________________________

Email: ______________________________

Authorized Signature: ______________________________

Send additional copy of invoice to: ______________________________

Send Additional Reports to:

Attention To: ______________________________

Facility Name: ______________________________

Address: ______________________________ Phone #: ______________________________

______________________________ Fax #: ______________________________

Email: ______________________________