EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Neurology - Neuromuscular Laboratory
101 Woodruff Circle, Room 6310(WMB)
Atlanta, GA 30322

Biopsy Requisition Form

Pt. Name: _____ DOB: _____ Sex: _____

Date of Biopsy: _____ Site of Biopsy: _____ Your ID #: _____

Surgeon: _____ Office #: _____

Address _____ FAX #: _____

Referring Physician: _____ Office #: _____

Address _____ FAX #: _____

We bill the facility sending biopsy requisition documents. **We do not bill the patient or their insurance carrier.**

Missing billing and payment contact information may cause administrative delay.

Bill to Facility Name _____

Bill to Facility PO #/Internal Ref#: _____

Payment Inquiry to: Name: _____

Phone# _____ Fax# _____ Email _____

Authorized Signature: _____

Printed Name: _____

Send additional copy of Invoice to: _____

Brief Clinical History (Include as much information as possible or attach clinic note if possible):

_____

_____

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Biopsy Requisition Form

Diagnostic Considerations: _____

EMG Date: _____

EMG Findings (please attach EMG report if available):

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CK Levels/Date: _____ Diagnosis Code: _____

Comments:

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_____

Submitted by: _____ Phone #: _____

Send Additional Reports to:

Attention to: _____

Facility Name: _____

Address: _____

_____

Phone# _____Fax# _____Email _____

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