Epidemal Nerve Fiber Density Form:
516 Delaware St SE
Room 12-229 PWB
Minneapolis, MN 55455-0377

Ph: 612-625-1431 Fax: 612-626-5671

Shipping Check List (All shipments should include all of the following items)

☐ Specimen(s) ☐Insurance Info ☐Order Form ☐ Recent Clinical Note

TODAY'S DATE:	BIOPSY PERFORMED: DATE: TIME:	BIOPSY SENT: DATE: TIME:

REFERRING PHYSICIAN / SEND REPORT TO:	**Patient Information [PLACE LABEL HERE]:**
PROVIDER/PHYSICIAN NAME:	**NAME:**
Address:	**MRN:**
City, State, Zip:	**GENDER:** ☐ MALE ☐ FEMALE **DOB:**
Phone: (___)_________________	**Address:**
Fax: (___)_________________	**City, State, Zip:**
	Phone: (___)_____________

BIOPSY PHYSICIAN NAME (PLEASE PRINT)**:** _________________________

PATIENT BILLING INFORMATION- Attach copy of insurance card or data page (If not available, please provide):

Primary Insurance Company Name: ID #: Group #:

Secondary Insurance Company: ID# Group #:

Policyholder Name: Date of Birth: Relationship to Patient:

Patient location: ☐ Inpatient ☐ Outpatient

Number of Specimen(s):__________

Biopsy Location 1:_____________________ Description (optional) :__________________

Biopsy Location 2:_____________________ Description (optional) :__________________

Biopsy Location 3:_____________________ Description (optional) :__________________

Biopsy Location 4:_____________________ Description (optional) :__________________

Biopsy Location 5:_____________________ Description (optional) :__________________

SYMPTOMS (check all that apply)**:**	**CAUSE OF NEUROPATHY** (If known)
☐Numbness ☐Pain ☐Tingling ☐ Other (Please specify) ___________	

Revision Date: 11/2022