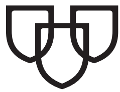

MAYO CLINIC LABORATORIES

Electron Microscopy Technical Only Patient Information

Instructions: To help provide the best possible service, complete the information below and send paperwork with the specimen.

Patient Information (required)

Patient Name (Last, First Middle)

Birth Date (mm-dd-yyyy)

Second Identifier (Medical Record Number)

Sex Assigned at Birth
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose

Legal/Administrative Sex
☐ Male ☐ Female ☐ Nonbinary

Referring Healthcare Professional Information

Referring Healthcare Professional Name (Last, First)

Phone

Fax*

Email

Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

Reason for Testing

☐ Renal pathology, differential diagnosis:

☐ Storage disease, specify: ______________________________
☐ Ciliary morphology
☐ CADASIL

☐ Tumor, differential diagnosis:

☐ Microvillous inclusion
☐ Other: ______________________________

Patient History/Pathologist Comments

____
____
____
____
____
____

Specimen Type

☐ Fixed wet tissue (check fixative used) ☐ Trumps ☐ 2.5%–3% glutaraldehyde ☐ Other: ______________________________
☐ Resin blocks
☐ Grids

Specimen/Sample ID (identifier to be used on digital image label)

Tissue Source

☐ Kidney ☐ Cilia ☐ Liver ☐ Skin ☐ Duodenum ☐ Heart
☐ Other: ______________________________

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