Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Electron Microscopy Patient Information

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

Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)
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*
Genetic Counselor Name (Last, First)	Phone	Fax*

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

Reason for Testing

☐ CADASIL
☐ Ciliary morphology (eg, primary ciliary dyskinesia)
☐ Other:
☐ Connective tissue disorder, specify:
☐ Storage disease, specify:

Patient History/Pathologist Comments

Specimen Fixative

☐ Trump's fixative	☐ 2.5%–3% glutaraldehyde	☐ Other (call lab before submitting)

Specimen Type

☐ Skin ☐ Whole blood ☐ Ciliary brushing ☐ Buffy coat ☐ Nasal ☐ Trachea
☐ Heart (only available through test ANPAT / Anatomic Pathology Consultation, Wet Tissue)
☐ Other:

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