ALL CHILDREN'S HOSPITAL
Pathology and Laboratory Medicine
Outpatient Care Center - 4th Floor
601 5th Street South
St. Petersburg, Florida 33701

Anatomic Pathology Requisition

Patient Name: _____ Birth Date:_____
Date of Surgery: _____
Pre-Op Diagnosis: _____ Age: _____
Post-Op Diagnosis: _____
Procedure: _____ MRN: _____

Surgeon(s): _____ Phone No.: _____

Hospital\Clinic: _____

Muscle/Nerve Biopsy

The following information is required for all patients undergoing a muscle/nerve biopsy:

Muscle Site: _____

Date of BX: _____ Time of BX: _____

Nerve Condition/EMG studies: No ___ Yes (results) _____

Family History of Muscle Disease: No ___ Yes _____

Developmental Problems: No ___ Yes _____

Weakness (onset): No ___ Yes _____

Muscle Pain: No ___ Yes _____

Skin Rash: No ___ Yes _____

CK: No ___ Yes _____

Genetic Study: No ___ Yes _____

Please Send Patient's History With Specimen

Submitted By: _____ Phone No.: _____

Send Results To (Physician's Name & Fax No.): _____