

*REQUIRED FIELDS

SKIN BIOPSY TEST SELECTION* (Please check the panel or tests from the listing below)
PANELS:

- Small Fiber Neuropathy Evaluation** - Epidermal Nerve Fiber Density (ENFD), Amyloidosis (AST), reflex to Sweat Gland Nerve Fiber Density (SGNFD) if ENFD is normal
 Small Fiber Sensory Neuropathy with Amyloidosis Screen - Epidermal Nerve Fiber Density (ENFD) and Congo Red Stain for Amyloidosis (AST)
 Small Fiber Sensory and Autonomic Neuropathy Evaluation - ENFD, SGNFD and AST

INDIVIDUAL TESTS:

- Congo Red Stain for Amyloidosis** - AST
 Epidermal Nerve Fiber Density - ENFD
 Sweat Gland Nerve Fiber Density - SGNFD

PATIENT INFORMATION*

FIRST NAME:	MI:	LAST NAME:	SUF:
SEX: <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.:	SS #:	
ADDRESS:			
CITY/STATE/ZIP:			
PHONE #:	MOBILE #:		
PCP NAME:	PCP PHONE #:		

SUBMITTING FACILITY

ONLINE REQUISITION FORM
 Please print the submitting Doctor's name and address below.

PATIENT INSURANCE INFORMATION* (Complete below or attach a copy of the insurance card and/or face sheet.)

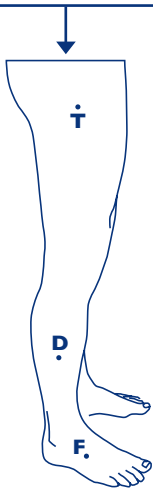
PRIMARY INSURANCE:	SECONDARY INSURANCE:		
ID/SUBSCRIBER/POLICY #:	ID/SUBSCRIBER/POLICY #:		
GROUP #:	PHONE #:	GROUP #:	PHONE #:
INSURED'S NAME:	INSURED'S NAME:		
EMPLOYER NAME:	PHONE #:	EMPLOYER NAME:	PHONE #:

CLINICAL INFORMATION*
DIAGNOSIS CODES (ICD9 Codes):
CLINICAL HISTORY:
BIOPSY LOCATIONS (Biopsy depth: minimum 4mm)

The three standard sites: (see diagram below for exact site locations)
Thigh (T) – Lateral Thigh, 20 cm below the iliac spine, at the level of the pubis
Distal Leg (D) – 10 cm above the lateral malleolus (calf)
Foot (F) – dorsum of the Foot, over the extensor digitorum brevis muscle

SPECIMEN COLLECTION*

DATE: _____
 TIME: _____ AM PM



Please indicate the biopsy location(s) below and label the vial(s) with the corresponding site and patient's name.

Sample A location	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> thigh	<input type="checkbox"/> distal leg	<input type="checkbox"/> foot
Sample B location	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> thigh	<input type="checkbox"/> distal leg	<input type="checkbox"/> foot
Sample C location	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> thigh	<input type="checkbox"/> distal leg	<input type="checkbox"/> foot
Sample D location	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> thigh	<input type="checkbox"/> distal leg	<input type="checkbox"/> foot

Authorization to Release Information and Pay Benefits: I consent to have testing services performed on my sample that is being sent to Therapath. I authorize Therapath to provide my insurance company with all of the necessary information, including test results, that is needed to receive payment for my laboratory tests. I also authorize that benefits under this claim be payable directly to Therapath. I agree to submit within 15 days, to Therapath, any payment for these laboratory services that were made directly to me. I authorize Therapath to file any appeal, grievance or claim review to my insurance carrier on my behalf.

I agree and acknowledge that if I do not have applicable insurance coverage or my insurance company denies coverage for services rendered by Therapath, LLC, I will be personally responsible for payment to Therapath, LLC for such services. I further agree and acknowledge that any court action between Therapath, LLC and myself, including, but not limited to, issues relating to payment shall be brought in a court of appropriate jurisdiction in New York County, New York. Therapath, LLC may, at its sole discretion, choose to bring any such action in the jurisdiction in which I reside.

THERAPATH USE

CI _____ VR _____ AN _____ AT _____ FE _____

***Patient Signature:** _____