THERAPATH
NEUROPATHOLOGY

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*REQUIRED FIELDS

Version #: 12-2015

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

PANELS:

☐ **Small Fiber Neuropathy Evaluation** - ENFD with AST and SGNFD only if ENFD is normal
☐ **Small Fiber Sensory Neuropathy with Amyloidosis Screen** - ENFD with AST
☐ **Small Fiber Sensory and Autonomic Neuropathy Evaluation** - ENFD with AST and SGNFD

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: ☐ M ☐ 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:

CLINICAL HISTORY:

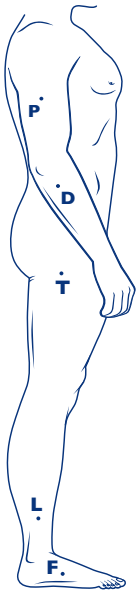
STANDARD BIOPSY LOCATIONS (Depth: minimum 4mm)

Proximal Arm (P) – Lateral surface midway between the shoulder (acromium) and the elbow
Distal Arm (D) – Upper (hairy or dorsal) surface of the forearm, 5 cm above the wrist
Thigh (T) – Lateral Thigh, 20 cm below the iliac spine, at the level of the pubis
Distal Leg (L) – 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

Medicare patient status at time of biopsy (check one):
☐ Hospital Inpatient (POS 21) ☐ Ambulatory Surgery (POS 24)
☐ Outpatient Clinic (POS 22) ☐ Physician Office (POS 11)



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

Sample A:	☐ **left**	☐ **right**	☐ **prox. arm**	☐ **distal arm**	☐ **thigh**	☐ **distal leg**	☐ **foot**
Sample B:	☐ **left**	☐ **right**	☐ **prox. arm**	☐ **distal arm**	☐ **thigh**	☐ **distal leg**	☐ **foot**
Sample C:	☐ **left**	☐ **right**	☐ **prox. arm**	☐ **distal arm**	☐ **thigh**	☐ **distal leg**	☐ **foot**
Sample D:	☐ **left**	☐ **right**	☐ **prox. arm**	☐ **distal arm**	☐ **thigh**	☐ **distal leg**	☐ **foot**

Authorization to Release Information and Pay Benefits: I consent to have testing services performed by Therapath on my sample. I hereby authorize and request that my insurer pay any benefits due for these services directly to Therapath. I authorize Therapath to provide my insurer with all of the necessary information, including test results, that is needed to receive payment for these tests I further authorize my insurer to provide Therapath with all pertinent information concerning coverage, payments, appeals and grievances. I agree to submit within 15 days, to Therapath, any payment for these 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 to be personally and fully responsible for any portion of the claim not covered by my insurer and agree to make such payment to Therapath within 30 days of receiving notice. A service charge of 1.5% per month may be charged on balances over 30 days. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default. 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.

***Patient Signature:** _____

THERAPATH USE
CI _____ VR _____ AN _____ AT _____ FE _____ FT _____