Cleveland Clinic
Neurological Institute
9500 Euclid Avenue, S-90
Cleveland, Ohio 44195

Cleveland Clinic Cutaneous Nerve Laboratory

Skin Biopsy Referral Form

☐ Referring a **Patient** for Skin Biopsy at Cleveland Clinic ☐ Requesting a **Biopsy Kit** for Local Skin Biopsy

Patient Name: Last_____ **First**_____ **M.I.**_____

Date of Birth: _____ **Gender:** _____ **Phone:** _____

Address: _____

Note: Control values are generated for an adult population. We do not have pediatric control values.

Referring Provider Name: Last_____ **First**_____ **M.I.**_____

Provider NPI: _____ **Provider E-mail Address:** _____

Provider Phone: _____ **Provider Fax** (for results)**:** _____

Shipping Address: _____

_____

Clinical Diagnosis: _____ **ICD Code(s):** _____

Reason for Biopsy/Brief Clinical History: _____

_____

Biopsy Site: ☐ Routine: Distal leg Distal thigh **Side:** ☐ R ☐ L

☐ For **alternate** biopsy sites, prior consultation with the lab director is **required**.
Call lab at 216-444-4131 or email NeuroSkinLab@ccf.org
Alternate site(s): _____ Consult Date: _____

Signature of Referring Provider: _____
(signature required)

Shipping Specimen Use ONLY:

Biopsy Performed by: _____
(signature required)

Biopsy Date: _____ **Time of specimens into fixative:** _____ am pm

Please contact lab with any questions. Lab Phone: 216-444-4131 Email: NeuroSkinLab@ccf.org
Forms and protocols available at www.clevelandclinic.org/skin-biopsies

Fax completed form to 216-445-1563 with a copy of the patient's insurance card(s)