



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

<b>Lab Use Only</b> Accession #: _____ Provider license verified <input type="checkbox"/>
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**Cleveland Clinic Cutaneous Nerve Laboratory**  
**Skin Biopsy Referral Form**

Form is designed for patient referral or specimen referral

Referring Patient to the CC Skin Biopsy Lab     
  Shipping Specimen obtained in your office

**Patient Name: Last** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **First** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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

**Requesting Physician Name: Last** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **First** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Physician's E-mail Address:** \_\_\_\_\_

**Clinical Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**Signature of Requesting Physician:** \_\_\_\_\_

**Reason for Biopsy/Brief Clinical History:** \_\_\_\_\_

\_\_\_\_\_

Effective 2/15/2021, standard biopsy protocol has been reduced to 2 biopsy sites.  
 This change does not significantly alter sensitivity or specificity.

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

Alternate site\* (specify): \_\_\_\_\_

\*Requires consultation with lab prior to biopsy

**Shipping Specimen Use ONLY:**

**Biopsy Performed by:** \_\_\_\_\_ **Date of Biopsy:** \_\_\_\_\_  
 (signature required)

**Time of specimens into fixative** \_\_\_\_\_ am pm

Any questions regarding biopsy specimen shipping and processing please visit us online, call or email us.

**Please Fax or Scan and E-mail this completed form and a copy of the patient's insurance card**