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

Lab Use Only
Accession #: _____
Provider license verified ☐

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: _____

_____

Biopsy Site: ☐ Routine: Distal leg Distal thigh Proximal 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

www.clevelandclinic.org/skin-biopsies **Lab Phone: 216-444-4131 Fax: 216-445-1563 Email: NeuroSkinLab@ccf.org**