



**Instructions:** To help provide the best possible service, supply the information requested below and send paperwork with the specimen.

**Patient Information**

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Pathologist Name <i>(Last, First)</i>	Phone	Fax*

\*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

**Reason for Testing**

<input type="checkbox"/> CADASIL	<input type="checkbox"/> Mitochondrial disorder, specify: _____
<input type="checkbox"/> Ciliary morphology	<input type="checkbox"/> Storage disease, specify: _____
<input type="checkbox"/> Connective tissue disorder, specify: _____	<input type="checkbox"/> Tumor, specify: _____
<input type="checkbox"/> Other: _____	

**Patient History/Pathologist Comments**

**Specimen Fixative**

<input type="checkbox"/> Trumps fixative	<input type="checkbox"/> 2.5%–3% Glutaraldehyde	<input type="checkbox"/> Other (call lab before submitting)
--	---	---

**Specimen Type**

<input type="checkbox"/> Skin	<input type="checkbox"/> Whole blood	<input type="checkbox"/> Ciliary brushing	<input type="checkbox"/> Buffy coat	<input type="checkbox"/> Nasal	<input type="checkbox"/> Trachea	<input type="checkbox"/> Heart
<input type="checkbox"/> Other: _____						