Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Electron Microscopy Technical Only Patient Information

Patient Information

Patient Name *(Last, First, Middle)*		Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*		Medical Record Number (MRN)	
Referring Provider Phone	Fax*	Email	

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

Reason for Testing

☐ Renal pathology, differential diagnosis:	☐ Tumor, differential diagnosis:
☐ Storage disease, specify: _____	☐ Microvillous inclusion disorder
☐ Ciliary morphology	☐ Other: _____
☐ CADASIL	

Patient History/Pathologist Comments

Specimen Type

☐ Fixed wet tissue (check fixative used) ☐ Trumps ☐ 2.5%–3% Glutaraldehyde ☐ Other: _____

☐ Resin blocks

☐ Grids

Specimen/Sample ID (identifier to be used on digital image label)

Tissue Source

☐ Kidney ☐ Cilia ☐ Liver ☐ Skin ☐ Duodenum ☐ Heart

☐ Other: _____

Print