Muscular Dystrophy Biopsy Requisition

U I D L
U I Diagnostic Laboratories

MUSCULAR DYSTROPHY BIOPSY REQUISITION

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Fax: 319-384-7213

FOR CLIENT USE ONLY: Requisition Date:_____
Completed By: _____ Accn# _____

FOR UIDL USE ONLY: UIDL Case #
UIDL MRN#

PART A - PATIENT INFORMATION - *Required*

Patient Name:
Street:
City: | St: | Zip:
Phone: ( )
Date of Birth: | Gender: ☐Male ☐Female

PART B - PROVIDER INFORMATION - *Required*

Referring Institution:
Street:
City: | St: | Zip:
Phone: ( ) | Fax: ( )
Referring Physician:
Referring Physician NPI:

PART C – SPECIMEN INFORMATION - *Required*

SPECIFY FROZEN BIOPSY (ship on dry ice, refer to the UIDL TEST DIRECTORY for specimen requirements.)

☐ Muscle (Duchenne, Becker, LGMD, CMD, Emery-Dreifuss)
☐ Skin (Emery-Dreifuss or CMD)
☐ Other Site (Emery-Dreifuss only)
Describe: _____
Biopsy Date: _____
Biopsy Site: _____

SEND SAMPLES TO:
Dr. Steven A. Moore
The University of Iowa Hospitals and Clinics
Department of Pathology, 5231 RCP
200 Hawkins Drive
Iowa City, IA 52242

Office Phone: (319) 384-9084
Fax: (319) 384-8053
E-mail: steven-moore@uiowa.edu

TESTS RELEVANT TO CURRENT PROBLEM: CK _____ EMG _____
Other: _____

CLINICAL DIAGNOSIS:

CLINICAL HISTORY & FINDINGS / FAMILY HISTORY (continue on back of form if necessary):

ADDITIONAL CONTACT INFORMATION

PATIENT'S PHYSICIAN
Name: _____
Street: _____
City, State, Zip: _____
Phone: _____ Fax: _____
E-mail: _____

REFERRING PATHOLOGIST
Name: _____
Street: _____
City, State, Zip: _____
Phone: _____ Fax: _____
E-mail: _____

PART D - SEND BILL TO: (Required)

☐ **Referring Institution** Contact Person: _____
Address: _____
City, State, Zip_____
Phone: _____ Fax: _____E-mail: _____
☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)
(*Required information is in red*)

Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.
OR
(2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for the Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens. *MDBR 05/08*