# EPIDERMAL NERVE FIBER DENSITY REQUISITION FORM

E56501

bako
Integrated Physician Solutions

Bako Pathology Services
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LabForms 888-200-5114

**PHYSICIAN/CLINIC INFORMATION**

**BILL:** ☐ **INSURANCE** ☐ **PATIENT**

**PATIENT INFORMATION**

| LAST NAME | FIRST NAME | M.I. |
|---|---|---|
| STREET ADDRESS | | APT. # |
| CITY | STATE | ZIP CODE |
| PHONE NUMBER | | |
| DATE OF BIRTH / / | AGE | SEX / PATIENT ID |

**BILLING/INSURANCE INFORMATION** (ATTACH A COPY OF INSURANCE CARD - BOTH SIDES)

| **SUBSCRIBER PRIMARY INSURANCE** | | | **SUBSCRIBER SECONDARY INSURANCE** | | |
|---|---|---|---|---|---|
| SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent | | | SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent | | |
| INSURANCE NAME | | | INSURANCE NAME | | |
| ADDRESS | | | ADDRESS | | |
| CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE |
| SUBSCRIBER DOB: / / | GROUP/CONTRACT # | MEMBER ID # | SUBSCRIBER DOB: / / | GROUP/CONTRACT # | MEMBER ID # |
| SUBSCRIBER SEX: ☐ Male ☐ Female | MEDICARE ID # | MEDICAID ID # | SUBSCRIBER SEX: ☐ Male ☐ Female | MEDICARE ID # | MEDICAID ID # |

**ICD-10 CODE**

☐ G60.9 (Hereditary and idiopathic neuropathy, unspecified)
☐ G60.8 (Other hereditary idiopathic neuropathies)
☐ Other _____

**CLINICAL INFORMATION**

**DATE COLLECTED**____/____/____ **TIME COLLECTED**_____ **REPEAT BIOPSY** ☐

**Shipped in:** ❑ **Zamboni's/#1** (24-hr maximum exposure) ❑ **Cryoprotectant/#3** (after >8 hours Zamboni's fixation and rinse)**

**For specimen fixation and rinsing techniques video instruction is available at **www.bakocts.com**

Indicate Test Selected: ❑ Epidermal Nerve Fiber Density (ENFD)
❑ ENFD and Amyloid Stain* *In Cases of Lymphoma, Myeloma, Familial Amyloidosis, Etc.

AFFIXED LABEL

| Indicate Test Site | Circle Laterality | Circle Laterality | Circle Laterality |
|---|---|---|---|
| Sample A Site<br>Name: | ❑ Calf L or R | ❑ Thigh L or R | ❑ Other_____ L or R |
| Sample B Site<br>Name: | ❑ Calf L or R | ❑ Thigh L or R | ❑ Other_____ L or R |
| Sample C Site<br>Name: | ❑ Calf L or R | ❑ Thigh L or R | ❑ Other_____ L or R |
| Sample D Site<br>Name: | ❑ Calf L or R | ❑ Thigh L or R | ❑ Other_____ L or R |

**PHYSICIAN SIGNATURE**

**SIGNATURE REQUIRED**

**PATIENT SIGNATURE**

I authorize Bako Pathology Services, LLC to bill my insurance.
SIGNATURE _____ DATE: ____/____/____

**SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL**

REQ. VERSION 3/30/2016