EPIDERMAL NERVE FIBER DENSITY REQUISITION FORM

Bako Diagnostics
6240 SHILOH ROAD
ALPHARETTA, GA 30005
PH: 877-376-7284 • FAX: 770-475-0533

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

PATIENT INFORMATION

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

BILL: ☐ **INSURANCE** ☐ **PATIENT**

BILLING/INSURANCE INFORMATION (Attach a copy of primary / secondary insurance cards — both sides)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent	INSURANCE NAME
MEMBER ID	ADDRESS
GROUP/CONTRACT #	CITY / STATE / ZIP

ICD-10 CODE

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

CLINICAL INFORMATION

DATE COLLECTED____/____/____ **TIME COLLECTED** ____:____**AM PM** **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.bakodx.com

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

Indicate Test Site	Circle Laterality	Circle Laterality	Circle Laterality
Sample A Site Name	☐ Calf L or R	☐ Thigh L or R	☐ Other_____ L or R
Sample B Site Name	☐ Calf L or R	☐ Thigh L or R	☐ Other_____ L or R
Sample C Site Name	☐ Calf L or R	☐ Thigh L or R	☐ Other_____ L or R
Sample D Site Name	☐ Calf L or R	☐ Thigh L or R	☐ Other_____ L or R

PHYSICIAN SIGNATURE

The requested test(s) is/are medically indicated for patient management.

SIGNATURE REQUIRED

I authorize Bako Diagnostics to bill my insurance.

SIGNATURE _____ DATE ____/____/____

SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL

REQ. VERSION 040418

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