University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

**Regional Pathology Services**
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
FAX: 402.559.9497

# Electron Microscopy Test Request Form

**RPS Use Only**

Accession #: _____

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME | FIRST NAME | MI

DOB / / | GENDER ☐ MALE ☐ FEMALE | PT. ID# / ADDITIONAL INFO

SSN - - | BILL ☐ OFFICE/CLIENT ☐ PATIENT INSURANCE

**Collection Date** _____/_____/_____ **Collection Time** _____ **AM PM**

PROVIDER: _____
(First, Last, MI)

**PATIENT INSURANCE**
**ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED**

**GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)**

ADDRESS | CITY | STATE | ZIP

**PRIMARY INSURANCE**
☐ **MEDICARE IN-PATIENT** ☐ **MEDICARE OUT-PATIENT** ☐ **MEDICAID** ☐ **INSURANCE**

**POLICY ID#** | **GROUP ID#**

INSURANCE COMPANY | PHONE NUMBER

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

**EFFECTIVE DATE** / /

**DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)**

ICD-10 #1 | ICD-10 #2 | ICD-10 #3

**SECONDARY / TERTIARY INS – ATTACH INFORMATION**

NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. **FOR MORE INFORMATION SEE reglab.org/billingcompliance/**

☐ ABN ATTACHED
☐ PRIOR AUTHORIZATION ATTACHED

**NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis.** If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. ☐ **Check the box if additional reference laboratory testing is not desired.** Please note that a definitive diagnosis may not be possible.

**EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER** | **EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER**

## Electron Microscopy Test Request Form
## (Specimen Collection/Submission protocol – see back of form)

Electron Micoscopy

☐ EM Complete with Interpretation ☐ EM Process Only *

* Light microscopy only, no EM performed, but does include professional fee

### SPECIMEN FIXATIVE

___ EM FIXATIVE
___ 2.5%-3% GLUTARALDEHYDE
___ OTHER *(Please call before submitting)*

| Specimen Type | |
|---|---|
| | BUFFY COAT |
| | CILIARY BRUSHING |
| | DUODENUM |
| | HEART |
| | LIVER |
| | NASAL |
| | SKIN |
| | TRACHEA |
| | OTHER |

| REASON FOR REFFERRAL/PATIENT HISTORY | |
|---|---|
| | Bullous Disease |
| | CADASIL |
| | Ciliary Morphology |
| | Connective Tissue Disorder - Specify: |
| | Microvillous Inclusion Disorder |
| | Mitochondrial Disorder - Specify |
| | Tumor- Specify: |
| | Viral Inclusion |
| | Other: |

### FAMILY HISTORY

*Should include mother, father, siblings, children, maternal relatives, paternal relatives if relevant*

| Family Member | Details |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Pathologists Contact Information
## Dr. Kirk Foster 1-402-559-8412 or Dr. Geoffrey Talmon 1-402-559-4793

**FOR DETAILED TESTING INFORMATION VISIT REGLAB.ORG**

Supplies are ordered online at **reglab.org/customer-service/supply-orders/** testing supplies and log-on information may be obtained by calling client services
Toll Free: 800-334-0459
Phone: 402-559-6420