University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
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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

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

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

PROVIDER: _____
(First, Last, MI)

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**

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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)*

	WHOLE BLOOD/ BUFFY COAT
	CILIARY BRUSHING
	DUODENUM
	HEART
	LIVER
	NASAL
	SKIN
	TRACHEA
	WHOLE BLOOD/PLATELET
	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, pater-nal 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