The Children's Hospital *of* Philadelphia

Department of Pathology and Laboratory Medicine

Muscle Biopsy Requisition

Patient Information *(Required)*						Provider Information *(Required)*					
Patient Name						Referring Institution					
Address						Address					
Address						Address					
City		State		Zip		City		State		Zip	
Phone						Phone		Fax			
DOB		Gender	☐ Male ☐ Female			Referring Physician					
						E-Mail					

Specimen Information *(Required)*

Specimen ID#: _____
Biopsy Date: _____
Biopsy Site: _____

Muscle Biopsy
- ☐ Fresh
- ☐ Frozen (Liquid Nitrogen)
- ☐ Frozen (Isopentane)
- ☐ Formalin
- ☐ Glutaraldehyde

Send All Specimens To:
Department of Pathology and Laboratory Medicine
Children's Hospital of Philadelphia
34th Street and Civic Center Boulevard
Room 5NW27 – Main, 5th Floor
Philadelphia PA 19104-4318
215-590-1728
215-590-1736 FAX
Attention: Neuropathology

Testing Relevant To Current Problem *(Required)*

Please include complete copy of the patient's relevant pathology reports, including CK, and neurology testing, including EMG

Clinical Diagnosis:

Clinical History/Family History:

Billing Information *(Required)*

***Please note at this time we are not able to bill the patient's insurance directly for any services we provide ***

Referring Institution Billing Contact Person					
Billing Address					
City, State, Zip					
Phone		Fax		E-Mail	

Additional Contact Information

Patient's Physician				Pathologist			
Address				Address			
City, State, Zip				City, State, Zip			
Phone		Fax		Phone		Fax	

CHOP Internal Use Only

Date Received		Received By		CHOP ID	
Assigned Neuropathologist					
Comments					

By using and sending this Requisition Form to CHOP Outreach Lab for laboratory testing, you, the sender, acknowledge and agree that you have read and agree to the CHOP Terms and Conditions posted at www.chop.edu/labs and agree to pay CHOP the rates in CHOP's fee schedule in effect on the date the specimen is received.