Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Bone Histomorphometry: Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Phone Consultation Name *(Last, First)*		Phone
Report Sent To Name *(Last, First)*	Address *(Street, City, State, ZIP Code)*	

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing and Clinical Information (required)

Surgery Date *(mm-dd-yyyy)*	Surgeon Name *(Last, First)*
Biopsy Site	Has a biopsy been previously submitted? ☐ Yes ☐ No
Clinical Diagnosis/Indications for Biopsy	
Pertinent History	

Tetracycline Provide specific dates of tetracycline administration.

First Label: Drug Name		Second Label: Drug Name	
Date *(mm-dd-yyyy)*	Dose	Date *(mm-dd-yyyy)*	Dose
Date *(mm-dd-yyyy)*	Dose	Date *(mm-dd-yyyy)*	Dose
Date *(mm-dd-yyyy)*	Dose	Date *(mm-dd-yyyy)*	Dose
Date *(mm-dd-yyyy)*	Dose	Date *(mm-dd-yyyy)*	Dose

MCL Use Only

Accession Number

Print