Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Electron Microscopy Technical Only Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	
Birth Date *(mm-dd-yyyy)*	Second Identifier (Medical Record Number)
Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

Referring Provider Name *(Last, First)*	Phone
Fax*	Email

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

Reason for Testing

☐ Renal pathology, differential diagnosis:	☐ Tumor, differential diagnosis:
☐ Storage disease, specify: ☐ Ciliary morphology ☐ CADASIL	☐ Microvillous inclusion disorder ☐ Other:

Patient History/Pathologist Comments

Specimen Type

☐ Fixed wet tissue (check fixative used) ☐ Trumps ☐ 2.5%–3% Glutaraldehyde ☐ Other:

☐ Resin blocks

☐ Grids

Specimen/Sample ID (identifier to be used on digital image label)

Tissue Source

☐ Kidney ☐ Cilia ☐ Liver ☐ Skin ☐ Duodenum ☐ Heart

☐ Other:

Print