JOHNS HOPKINS
MEDICINE

This must be completed at time of exam if no prior authorization obtained.
Include a copy of the insurance card, front and back.
Missing information may cause delays.

Last name:

First name:

Date of birth:

Sex (circle one): Male Female

Address:

Weight: Height:

Phone number:

Primary insurance	Secondary insurance (if applicable)
Subscriber name: Subscriber birthdate: Relationship to subscriber: Insurance name: Group number: Policy number:	Subscriber name: Subscriber birthdate: Relationship to subscriber: Insurance name: Group number: Policy number:

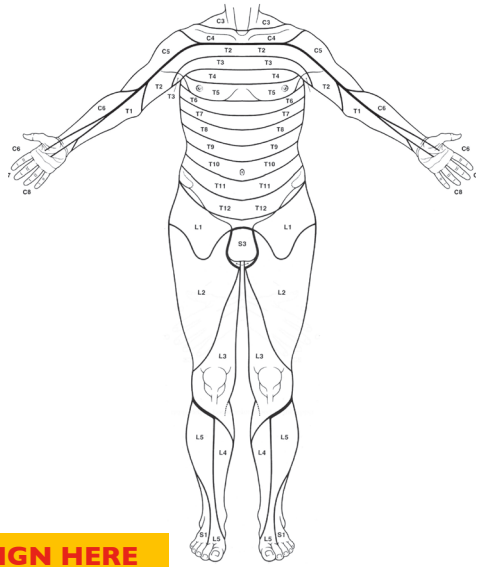
complete at time of exam

CUTANEOUS NERVE LAB

Reason for biopsy:

Is there a suspicion of amyloid? ☐
Should mass spectometry be performed, if possible? ☐

☐ Intraepidermal nerve fiber density (IENFD) & Congo Red for amyloidosis
☐ IENFD, Congo Red & sweat gland nerve fiber density (SGNFD)
☐ IENFD only



Physician Information

Name:

Address:

Phone:
Fax:

Email:

Anatomical sites (indicate quantity and specify site)

Distal Leg	Left __	Right __
Distal Thigh	Left __	Right __
Proximal Thigh	Left __	Right __

Alternate sites (specify and mark on diagram)

SIGN HERE

Physician signature:

Date:

Total # specimens:
Shipment date:
Biopsy date: