



Cleveland Clinic

Neurological Institute
9500 Euclid Avenue, S-90
Cleveland, Ohio 44195

Lab Use Only

Accession #: _____

Provider license verified ☐

**Cleveland Clinic Cutaneous Nerve Laboratory
Skin Biopsy Referral Form**

Form is designed for patient referral or specimen referral

☐ Referring Patient to the CC Skin Biopsy Lab

☐ Shipping Specimen obtained in your office

Patient Name: Last _____ **M.I.** _____ **First** _____

Date of Birth: _____ **Gender:** _____ **Phone:** _____

Address: _____

Note: Control values are generated for an adult population. We do not have pediatric control values.

Requesting Physician Name: Last _____ **M.I.** _____ **First** _____

Address: _____

Phone: _____ **Fax:** _____

Physician's E-mail Address: _____

Clinical Diagnosis: _____ **ICD Code:** _____

Signature of Requesting Physician: _____

Reason for Biopsy/Brief Clinical History: _____

Effective 2/15/2021, standard biopsy protocol has been reduced to 2 biopsy sites.
This change does not significantly alter sensitivity or specificity.

Biopsy Site: ☐ Routine: Distal leg Distal thigh **Side:** ☐ R ☐ L

☐ Alternate site* (specify): _____

*Requires consultation with lab prior to biopsy

Shipping Specimen Use ONLY:

Biopsy Performed by: _____
(signature required)

Date of Biopsy: _____

Time of specimens into fixative _____ am pm

Any questions regarding biopsy specimen shipping and processing please visit us online, call or email us.

Please Fax or Scan and E-mail this completed form and a copy of the patient's insurance card

www.clevelandclinic.org/skin-biopsies Lab Phone: 216-444-4131 Fax: 216-445-1563 Email: NeuroSkinLab@ccf.org