IMMUNOFLUORESCENCE (IMF) REQUISITION FORM

Lab Accession Number: (HCMC Lab Use Only) _____

Hennepin Healthcare	**Hennepin County Medical Center** **Anatomic Pathology Laboratory** **Attn: Histology Lab** **701 Park Avenue, Room PL.730** **Minneapolis, MN 55415** **Telephone: 612-873-3079** **Fax: 612-904-4629**

(Please fill in or use label)

Patient Name: (Last, First MI)	**Date/time of Biopsy:**
Address:	**Clinic:**
City: State: Zip:	**Clinic Address:**
Phone Number:	**City: State: Zip:**
Date of Birth:	**Physician: NPI:**
Gender:	**Additional Results to:**
Clinic ID Number:	**Results to: Tel# Fax#**

SPECIMEN (type and site):_____ [ ] Inpatient [ ] Outpatient

SKIN BIOPSY:

CLINICAL HISTORY/DIAGNOSIS (please provide Clinical Symptoms/Reason for Biopsy or ICD10 Code):
[ ] Rash [ ] Blisters [ ] Pustules [ ] Vesicles [ ] Macules [ ] Other, specify:_____
_____

HEART BIOPSY: TRANSPLANT [ ] Yes [ ] No

TEST REQUESTED: [ ] Light microscopy [ ] Immunofluorescence tests
[ ] Other test, specify:_____

SPECIMEN TRANSPORT MEDIA: [ ] 10% Formalin [ ] Michel's Buffer for Immunofluorescence
[ ] Other, specify:_____

BILLING INFORMATION

[ ] Bill Hospital or Clinic Listed Above

[ ] Bill Patient Directly
Please provide patient demographics & insurance information

Medicare billing policy prevents us from submitting a Medicare claim for laboratory testing referred to us on hospital inpatients or hospital outpatients. For these samples, we will bill the sending hospital.

For Anatomic Pathology Laboratory Use
Received Date Number of piece(s) Measurement [diameter of epithelial surface x depth of specimen in cm]