

**UAMS DEPARTMENT OF PATHOLOGY
Muscle / Nerve Biopsy Request Form**

Patient Name: _____ DOB: _____ M F

Muscle biopsy Nerve biopsy Site: _____

Your Patient # _____ Physician: _____

Requesting Facility Name and Address:

Requesting Facility Phone: () _____

FAX reports to: () _____

Clinical history, differential diagnosis, special requests:

List all physicians desiring a copy of the report, with FAX numbers if available.

**Ship by courier or by overnight express to:
Histology Laboratory
Department of Pathology
Room S4/21 Shorey Building
University of Arkansas for Medical Sciences
4301 West Markham Street
Little Rock, AR 72205**