ADVANCED LABORATORY SERVICES

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TEST SELECTION* (Check the appropriate testing option from the selection below)

*REQUIRED FIELDS

INDIVIDUAL TESTS:
- ☐ ENFD - Epidermal Nerve Fiber Density with PGP9.5 antibody
- ☐ SGNFD - Sweat Gland Epidermal Nerve Fiber Density with PGP9.5 antibody

PANEL TEST:
- ☐ Small Fiber Neuropathy Evaluation - ENFD and SGNFD only if ENFD is normal

PATIENT INFORMATION*

FIRST NAME | MI | LAST NAME

SEX: ☐ M ☐ F | D.O.B. | SS #:

ADDRESS:

CITY: | STATE: | ZIP CODE:

PHONE #:

MOBILE # (optional):

SUBMITTING FACILITY

ORDERING PHYSICIAN: (name, address)

NPI #: | PHYSICIAN SIGNATURE :

PHYSICIAN PHONE #:

PHYSICIAN FAX #:

PATIENT INSURANCE INFORMATION* (Complete below or attach a copy of the insurance card and/or face sheet)

PRIMARY INSURANCE:

ID/SUBSCRIBER/POLICY #:

GROUP #: | PHONE #:

INSURED'S NAME

EMPLOYER NAME | PHONE #:

SECONDARY INSURANCE:

ID/SUBSCRIBER/POLICY #:

GROUP #: | PHONE #:

INSURED'S NAME

EMPLOYER NAME | PHONE #:

CLINICAL INFORMATION*-- ICD10 CODE & CLINICAL HISTORY REQUIRED

DIAGNOSIS CODES (ICD10 Codes):

- ☐ R20.2 Paresthesia of skin
- ☐ R20.0 Anesthesia of skin
- ☐ R20.1 Hypoesthesia of skin
- ☐ R20.3 Hyperesthesia
- ☐ R20.8 Other disturbances of skin sensation
- ☐ R20.9 Unspecified disturbances of skin sensation
- ☐ G90.09 Other idiopathic peripheral autonomic neuropathy
- ☐ G90.9 Disorder of the autonomic nervous system, unspecified
- ☐ G60.0 Hereditary motor and sensory neuropathy
- ☐ G60.3 Idiopathic progressive neuropathy
- ☐ G60.8 Other hereditary and idiopathic neuropathies
- ☐ G60.9 Hereditary and idiopathic neuropathy, unspecified
- ☐ E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy
- ☐ E09.42 Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
- ☐ E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy
- ☐ E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
- ☐ E13.42 Other specified diabetes mellitus with diabetic polyneuropathy
- ☐ G62.1 Alcoholic polyneuropathy

Are there clinical findings to suggest Neuropathy? Circle: Yes or No

What are the findings?
- ☐ Pinprick test negative?
- ☐ Vibration of toes negative?
- ☐ Ankle reflexes absent?

CLINICAL HISTORY/RULE OUT DIAGNOSIS*:

Is this test to EXCLUDE Neuropathy? Circle: Yes or No

☐ Toxic ☐ Infectious ☐ Painful small fiber neuropathy ☐ Numbness/paresthesias ☐ Metabolic ☐ CIDP

☐ History of diabetes ☐ Burning/tingling sensations ☐ Abnormal EMG? ☐ OTHER:_____

SPECIMEN COLLECTION*

DATE:

TIME ☐ AM ☐ PM

BIOPSY LOCATIONS* (Biopsy size: 3mm width, 4 mm depth)

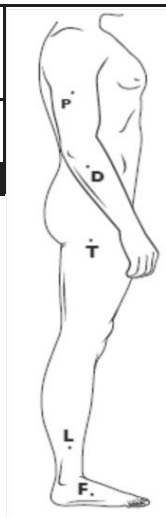
Thigh (T) – Lateral Thigh, 20 cm below the iliac spine, at the level of the pubis

Distal Leg (L) – 10 cm above the lateral malleolus (calf)

Foot (F) – Dorsum of the Foot, over the extensor digitorum brevis muscle

Proximal Arm (P) – Lateral surface midway between the shoulder (acromium) and the elbow

Distal Arm (D) – Upper (hairy or dorsal) surface of the forearm, 5 cm above the wrist



EACH TUBE must be labeled with patient name, DOB, Biopsy Site and Side (Left or Right)

Left Thigh (T)
Name:_____
DOB:_____

Left Distal Leg (L)
Name:_____
DOB:_____

Left Foot (F)
Name:_____
DOB:_____

Right Thigh (T)
Name:_____
DOB:_____

Right Distal Leg (L)
Name:_____
DOB:_____

Right Foot (F)
Name:_____
DOB:_____

Other Site #1:_____
Name:_____
DOB:_____

Other Site #2:_____
Name:_____
DOB:_____

Other Site #3:_____
Name:_____
DOB:_____

Authorization to Release Information and Pay Benefits: I consent to have testing services performed on my sample being sent to Advanced Laboratory Services (ALS). I authorize ALS to provide my insurance company with all of the necessary information, including test results, that is needed to receive payment for my laboratory tests. I also authorize that benefits under this claim may be payable direcly to ALS. I agree to submit within 15 days, to ALS, any payment for these laboratory services that were made directly to me. I authorize ALS to file any appeal, grievance or claim review to my insurance carrier on my behalf. I agree and acknowledge that if I do not have applicable insurance coverage or my insurance company denies coverage for services rendered by ALS, I will be personally responsible for payment to ALS for such services.

***Patient Signature**: _____