UCLA Health
PATHOLOGY OUTREACH SERVICES

NEUROPATHOLOGY REQUISITION

PATIENT NAME (LAST)	(FIRST)	(MI)

M.D. / CLIENT NAME ACCOUNT INFORMATION

GENDER ☐ M ☐ F

DATE OF BIRTH (MM/DD/YYYY) _____ /_____ /_____

ADDRESS

CITY	STATE	ZIP CODE	PHONE

BILL TYPE: ☐ M.D. / CLIENT ☐ PATIENT / INSURANCE

ATTACH DEMOGRAPHIC SHEET WITH INSURANCE INFORMATION

Indicate: Diagnosis / Signs / Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)	ICD-CM:	ICD-CM:	ICD-CM:	ICD-CM:

COPY TO (FULL NAME / FAX NUMBER):

SPECIMEN INFORMATION

COLLECTION DATE	COLLECTION TIME

CLIENT MRD / CASE #	BIOPSY SITE

☐ MUSCLE:_____ ☐ WHOLE BRAIN:_____ ☐ EM:_____ ☐ FRESH:_____ ☐ SLIDES:_____

☐ NERVE:_____ ☐ PARTIAL BRAIN:_____ ☐ FROZEN:_____ ☐ UNK. LIQUID:_____

DIAGNOSTIC QUESTION / DIFFERENTIAL DIAGNOSIS

CLINICAL HISTORY

Clinical History:

Cancer:

Rheumatoid Dx:

Family History:

Age at onset:

Onset:	☐ Acute	☐ Chronic		
Weakness:	☐ Proximal	☐ Distal	☐ Symmetric	☐ Asymmetric
Location:	☐ RUE	☐ LUE	☐ RLE	☐ LLE
Cramps:	☐ yes	☐ no		
Fasciculations:	☐ yes	☐ no		
Fatigue:	☐ yes	☐ no		
Myoglobinuria:	☐ yes	☐ no		
Exercise intol:	☐ yes	☐ no		
Atrophy:	☐ yes	☐ no		

Myotonia:	☐ yes	☐ no	
Rash:	☐ yes	☐ no	
Sensory:	☐ Numbness	☐ Paresthesia	☐ Dysesthesia
	☐ Proximal	☐ Distal	
	☐ Symmetric	☐ Patchy	
Chemotherapy:			
Radiation:			

MEDICATIONS

Statin:	☐ yes	☐ no	Duration:	Date (start/stop):
Steroid:	☐ yes	☐ no	Duration:	Date (start/stop):
Chemotherapy/Anti-PD1:	☐ yes	☐ no	Duration:	Date (start/stop):
Other:			Duration:	Date (start/stop):

LAB RESULTS & RADIOLOGY

Total CK: Lactate: Pyruvate: MRI:

ESR: Antibodies: EMG/NCS:

SHIP SPECIMENS TO: UCLA NEUROPATHOLOGY CLINICAL LAB
10833 LE CONTE AVENUE, 18-144 CHS, LOS ANGELES, CA 90095-1732
For shipping or technical questions, please contact Lab: 310-825-5792.
For all other questions, please contact Client Services: 310-267-2680 / FAX 310-267-2685