THERAPATH™

Shaded fields are required | #A2000000

TESTING OPTIONS

☐ **Epidermal Nerve Fiber Density with amyloid stain** *(Core)*
- ☐ **Add Sweat Gland Nerve Fiber Density** *(Comprehensive)*
- ☐ **Add Sweat Gland Nerve Fiber Density if ENFD is normal** *(Complete)*

INDIVIDUAL TESTS

☐ **Congo Red Stain for Amyloidosis** ☐ **Epidermal Nerve Fiber Density** – ENFD

☐ **Sweat Gland Nerve Fiber Density** – SGNFD

PROVIDER SIGNATURE Mandatory | **DATE TEST ORDERED**

X

PATIENT INFORMATION

First Name	MI	Last Name	Suf

Genetic Sex ☐ Male ☐ Female ☐ Unknown | D.O.B.

Address

City/State/Zip

Phone # | Mobile #

SPECIMEN COLLECTION

Date | Time ☐ AM ☐ PM

Place of Service (POS)
Patient status when specimen collected *(must choose one)*:

- ☐ Physician Office (POS 11)
- ☐ Ambulatory Surgery (POS 24)*
- ☐ Hospital Inpatient/CAH (POS 21)*
- ☐ Other _____
- ☐ Emergency Dept-Hospital/CAH (POS 23)*
- ☐ On-Campus Outpatient Hospital (POS 22)*
- ☐ Off-Campus Outpatient Hospital (POS 19)*

*** Was the specimen collected during an in-network hospital, CAH, ASC, or IDT visit?** ☐ Yes ☐ No

CLINICAL INFORMATION

Attach a copy of applicable medical records and electrodiagnostic studies

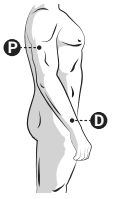
Possible ICD-10 symptoms and diagnoses
Ordering clinician should use the ICD-10 code that best describes the reason for performing the test, whether or not the code is listed on this requisition.

- ☐ **G60.3** - Idiopathic progressive neuropathy
- ☐ **G60.8** - Other hereditary and idiopathic neuropathy
- ☐ **G60.9** - Hereditary and idiopathic neuropathy, unspecified
- ☐ **G62.9** - Polyneuropathy unspecified
- ☐ **G64** - Other disorders of peripheral nervous system
- ☐ **G90.09** - Other idiopathic peripheral autonomic neuropathy
- ☐ **M79.2** - Neuralgia/neuritis - unspecified
- ☐ **R20.2** - Paresthesia of skin
- ☐ **R20.9** - Unspecified disturbances of skin sensation

SPECIMEN SITE

Write the patient name on the appropriate labels below, then peel off and apply to corresponding specimen vials.

	Side *(Select One)*	Body Site *(Select One)* **Standard site** details are located on the bottom of the requisition form. **Non-standard sites**, please indicate the specific location in "Other".	Specimen Labels *(Please discard unused labels)*
A	☐ Left ☐ Right	☐ Prox Arm ☐ Dist Arm ☐ Thigh ☐ Dist Leg ☐ Foot ☐ Other _____	**Specimen A** #A2000000 Patient Name: _____
B	☐ Left ☐ Right	☐ Prox Arm ☐ Dist Arm ☐ Thigh ☐ Dist Leg ☐ Foot ☐ Other _____	**Specimen B** #A2000000 Patient Name: _____
C	☐ Left ☐ Right	☐ Prox Arm ☐ Dist Arm ☐ Thigh ☐ Dist Leg ☐ Foot ☐ Other _____	**Specimen C** #A2000000 Patient Name: _____
D	☐ Left ☐ Right	☐ Prox Arm ☐ Dist Arm ☐ Thigh ☐ Dist Leg ☐ Foot ☐ Other _____	**Specimen D** #A2000000 Patient Name: _____



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

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

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

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THERAPATH USE	
TE	VR

THERAPATH™

Ordering clinician should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patients.

BILLING INFORMATION

Shaded fields are required | #A2000000

☐ Billing Insurance ☐ Bill Client ☐ Bill Patient ☐ Bill Other _____

PRIMARY INSURED BILLING INFORMATION				
Insurance Carrier	Policy Number / Insured ID Number		Group Number	
Claims Address			Policy Holder's Name	
City	State		Zip Code	Claims Phone Number
Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent	Policy Holder's D.O.B.	Sex ☐ Male ☐ Female	If Uninsured Patient ☐ Self Pay ☐ Indigent	
Policy Holder's Address	City	State	Zip Code	

SECONDARY INSURED BILLING INFORMATION				
Insurance Carrier	Policy Number / Insured ID Number		Group Number	
Claims Address			Policy Holder's Name	
City	State		Zip Code	Claims Phone Number
Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent	Policy Holder's D.O.B.	Sex ☐ Male ☐ Female	If Uninsured Patient ☐ Self Pay ☐ Indigent	
Policy Holder's Address	City	State	Zip Code	

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