

VANDERBILT UNIVERSITY MEDICAL CENTER  
REQUEST FOR DIAGNOSTIC ELECTRON MICROSCOPY  
Division of Electron Microscopy/Renal Pathology Laboratory  
C2317 Medical Center North, Nashville, TN 37232-2561  
Phone (615) 322-3070 \*\*\* Fax (615) 322-4840

To ensure faster service, please fill in all spaces completely when submitting tissue for EM.

"FOR VUMC CASES, PLEASE ATTACH COPY OF SURGICAL PATHOLOGY REPORT AND SEND A REPRESENTATIVE GLASS SLIDE"

Patient's Name: \_\_\_\_\_ Age/Date of Birth: \_\_\_\_\_ Sex/Race: \_\_\_\_\_

Accession Number: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_ SSN: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_ Pathologist's Name: \_\_\_\_\_

Resident's Name: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Tissue submitted in: 2% Glut \_\_\_\_\_ Paraffin Block \_\_\_\_\_ 10% Formalin \_\_\_\_\_ Slides \_\_\_\_\_

Clinical History: \_\_\_\_\_  
\_\_\_\_\_

Immunoperoxidase Studies: \_\_\_\_\_  
\_\_\_\_\_

Differential Diagnosis: \_\_\_\_\_

Tissue Source: \_\_\_\_\_

This case is \_\_\_\_\_ Clinically relevant or \_\_\_\_\_ Research

**REQUESTING OUTSIDE FACILITY INFORMATION (do not complete for in-house cases)**

Inpatient: \_\_\_\_\_ or Outpatient: \_\_\_\_\_ Bill Insurance: \_\_\_\_\_ Bill Client: \_\_\_\_\_

If applicable, please include all billing information for Patient-Bill Cases. Paperwork without insurance information would be billed to the client.

OUTSIDE PATHOLOGIST'S NAME, HOSPITAL NAME & ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_ UPIN Number: \_\_\_\_\_

REQUESTING CLINICIAN'S NAME, FACILITY NAME & ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_ UPIN Number: \_\_\_\_\_