



Center for Neuromuscular Disorders - Neuropathology Lab

Head: Prof K. Kleopa, MD, FAAN, Senior Consultant Neurologist

Request Form

Department Code: 23

Patient details Case type: Outpatient Inpatient

Name: _____ Surname: _____

D.O.B.: ____ / ____ / ____ I.D. No.: _____

Nationality: _____ Gender: Male Female

CING No. (if applicable): _____

Hepatitis B Status: +ve -ve Unknown

Hepatitis C Status: +ve -ve Unknown

HIV Status: +ve -ve Unknown

Patient status

GESY

Government-Non GESY Hospital Card No: _____

Private-Non GESY

Address: _____

City: _____ Code: _____ Country: _____

Phone: Home: _____ Work: _____

Case Information

Clinical Summary

Previous Laboratory Findings: _____

Test Required (Code No.) (Please tick accordingly)

1. Muscle Biopsy – Routine: H&E, Gomori, ATPase 9.4,4.6,4.3, SDH, NADH-TR, Cytochrome C, α-glycerophosphate, Oil Red O, PAS

2. Muscle Biopsy – Metabolic: Myophosphorylase, Phosphofructokinase, Adenylate deaminase

3. Muscle Biopsy – Inflammatory: MHC I, C5b9, Acid Phosphatase

4. Muscle Biopsy – Dystrophinopathy screen: Dys3,1,2, Utrophin, Spectrin

5. Muscle Biopsy – Dystrophy screen: α,β,γ,δ sarcoglycan, dysferlin, caveolin, merosin, α-dystroglycan, β-dystroglycan, collagen VI, spectrin

7. Muscle Biopsy – Paraffin: H&E Inflammatory, B & T cell, macrophage markers

Sample details (Please tick accordingly)

Date and Time of Sample Collection: _____

Sample: Muscle Nerve Other

Please specify: _____

First Investigation Repetition

Biopsy No _____

Referring clinician's / scientist's details

Name: _____ Surname: _____

Hospital / Clinic: _____

Requesting clinician's status

CING

Government (OKYπY)

Private-GESY GESY No: _____

Private-Non GESY

Address: _____

City: _____ Code: _____ Country: _____

Phone: _____ Fax: _____

Signature: _____ **Date:** ____ / ____ / ____

The referring physician undertakes and confirms understanding and compliance in respect of the mutual obligations as these are determined under the GDPR.

8. Muscle Biopsy – Developmental: Desmin, Vimentin, myosin, Utrophin

9. Nerve Biopsy – Paraffin: H&E, Congo Red

11. Nerve Biopsy – Frozen: Immunocytochemistry

12. Nerve Biopsy – Paraffin: H&E, B & T and macrophage markers

13. Whole Brain Examination

15. Other (please specify): _____

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PATIENT CONSENT FORM

DIAGNOSTIC TESTS NEUROPATHOLOGY LABORATORY

PATIENT NAME	<input type="text"/>	CING NO.	<input type="text"/>
DATE OF BIRTH	<input type="text"/>	SEX	<input type="text"/>
ID NO.	<input type="text"/>	HOSPITAL NO.	<input type="text"/>
PROCEDURE TO BE PERFORMED	<input type="text"/>	DATE	<input type="text"/>

I request and authorize the testing of my sample (or my child's), for the parameters indicate by the referring physician

- my biopsy my child's biopsy

The sample obtained through the biopsy will be further dissected by a trained laboratory technologist. A fraction of the sample will be frozen in liquid nitrogen and some will be fixed in paraffin. Depending on the requirements of the analysis, histology, histochemistry and immunohistochemistry will be performed on the sample. Further analysis may be carried out upon the physician's request.

The resulting test slides will be examined by a specialist who will determine whether more tests need to be carried out and who will eventually proceed with analysis interpretation and issue the report. A copy of the report will be stored in the patient's file, whereas an original copy of the report will also be sent to the referring physician.

Excess sample material will be stored for the purpose of result verification. This excess material may later constitute an important resource for diagnostic or research development which may aid in the establishment of novel diagnostic procedures. As emerging techniques or diagnostic tools become available this excess material may be used either for validation or as control tissue. Your sample may also be used in a pool of test samples for research purposes and applications.

All your personal data, including test results will be kept strictly confidential.

Please mark accordingly:

- I hereby agree to the aforementioned analysis procedure to be performed
 I hereby agree to the confidential use of my excess sample for future diagnostic and research development

PATIENT'S SIGNATURE

WITNESS'S SIGNATURE