Instructions for Tissue Preparation, Packaging and Shipping

Human Tissue: Always use universal precautions

Nerve Biopsy Kit Contents:

Combine vials A & B on the day of biopsy prior to fixation.
- **Vial A**: 12.0ml – Sodium Cacodylate Buffer (EM fixative)
- **Vial B**: 5.0ml - 8% Glutaraldehyde (EM fixative)
- **Vial C**: 10.0ml – 10% Formalin
- Index Card paper
- Styrofoam container
- One sealed biohazard bag
- Patient information form

Store solutions at 4˚C for up to 1 year.

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1. **NOTIFY THE MUSCLE & NERVE LABORATORY**

Please call 608-263-9184 a minimum of 24 hours before the biopsy is performed. The specimen should arrive in our laboratory between 9am and 4pm, Monday to Friday (no later than 4pm). **Fed-Ex specimens should be sent Monday through Thursday only.** If the sample is collected on Friday or on a day prior to a holiday the specimen will require same day delivery to UWHC by your local courier. Please call 608-263-9184 to verify. If a planned biopsy is cancelled or postponed, please let us know.

2. **SPECIMEN SPECIFICATIONS (OPERATING ROOM)**

The sural nerve biopsy should have a minimum length of 3.0cm, preferably 5.0cm in length. In the OR the fresh nerve must be placed on a flat surface, straight as possible and immediately sent to the pathology department. The specimen must **NOT** be immersed in saline.

3. **FRESH SPECIMEN HANDLING (PATHOLOGY DEPARTMENT)**

   **A.**
   - Lay nerve specimen straight out on a piece of index card; allow to sit 1-2 minutes for nerve to adhere to the card.
   - Combine vial A into vial B

   **B.**
   - Divide into segments while attached to index card.
   - Place: 2.0cm on index card into 10% Formalin (Vial C)
   - Place: 3.0cm on index card into 2.5% Glutaraldehyde (Vial A+B)

   **Note:** If smaller or greater than 5.0cm of nerve is received divide 1/3 for formalin, 2/3 for glutaraldehyde fixation.

   **C.**
   - Place both sealed vials (C and A+B), labeled with patients name and biopsy site, into sealed biohazard bag.
   - Place into the provided Styrofoam container with cold gel pack.
   - Include any available patient information and the completed UW Health Muscle & Nerve Biopsy Analysis Request form.

   **D.**
   - Address shipping container for delivery to: **University of Wisconsin Hospital and Clinics**
     600 Highland Avenue - Loading Dock, Room D4/136
     Madison, WI 53792
   - **Upon arrival call:** Muscle & Nerve Laboratory 608-263-9184
     - Call Muscle & Nerve Laboratory personnel with the package tracking number.
# MUSCLE & NERVE BIOPSY ANALYSIS REQUEST FORM

**PLEASE ADDRESS SHIPPING CONTAINER:**

UW HEALTH MUSCLE & NERVE LABORATORY  
600 HIGHLAND AVENUE – LOADING DOCK D4/136  
MADISON, WI 53792  
UPON ARRIVAL CALL: 608-263-9184

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## PATIENT INFORMATION:

|-------|----------|----------------|--------|------|------|--------|

## SPECIMEN COLLECTION INFORMATION:

### SKELETAL MUSCLE BIOPSY SITE(S):

<table>
<thead>
<tr>
<th>COLLECTION DATE:</th>
<th>COLLECTION TIME:</th>
<th>AM/PM</th>
<th>SURGEON:</th>
<th>PHONE #:</th>
</tr>
</thead>
</table>

### PERIPHERAL NERVE BIOPSY SITE(S):

<table>
<thead>
<tr>
<th>COLLECTION DATE:</th>
<th>COLLECTION TIME:</th>
<th>AM/PM</th>
<th>SURGEON:</th>
<th>PHONE #:</th>
</tr>
</thead>
</table>

## CLINICAL INFORMATION:

<table>
<thead>
<tr>
<th>CLINICAL DIAGNOSIS:</th>
<th>ICD-9 CODE:</th>
<th>CLINICAL HISTORY (IF CURRENT H&amp;P IS NOT ATTACHED):</th>
</tr>
</thead>
</table>

## EVALUATE FOR:

**SYMPTOMS (CIRCLE ALL THAT APPLY):**  
WEAKNESS  CRAMPS  MYALGIA

**DURATION:**  
_______YEARS  _______ MONTHS  _______ WEEKS

**EMG FINDINGS:**

**CPK CURRENT:**  
( / /2014)  

**CPK PREVIOUS:**  
( / /20 )

## BILLING INFORMATION:

<table>
<thead>
<tr>
<th>HOSPITAL/CLINIC NAME:</th>
<th>REQUESTING PHYSICIAN:</th>
<th>ADDRESS:</th>
<th>CITY/STATE/ZIP:</th>
<th>PHONE #:</th>
<th>FAX #:</th>
</tr>
</thead>
</table>

**MEDICAL ASSISTANCE:**  
YES  NO

**MEDICARE:**  
YES  NO

**PLEASE NOTE THAT IF MEDICAL ASSISTANCE OR MEDICARE ARE TO BE BILLED AN ATTACHED COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE CARD IS REQUIRED.**

## REPORT INFORMATION:

<table>
<thead>
<tr>
<th>HOSPITAL/CLINIC NAME:</th>
<th>REQUESTING PHYSICIAN:</th>
<th>ADDRESS:</th>
<th>CITY/STATE/ZIP:</th>
</tr>
</thead>
</table>

## REQUEST FORM COMPLETED BY: