MAYO CLINIC
Mayo Medical Laboratories

Bone Histomorphometry Information Sheet

Patient Name - *(Last Name, First Name, Middle Initial)*	Sex ☐ Male ☐ Female	Birth Date *(Month DD, YYYY)*
Physician Name - *(Last Name, First Name)*	Physician Phone	
MML Account Number *(if known)*		

Patient Information

Surgery Date *(Month DD, YYYY)*	Surgeon
Biopsy Site	Has a biopsy been submitted previously? ☐ Yes ☐ No

Clinical Diagnosis/Indications for Biopsy

Pertinent History

Tetracycline

Mandatory Requirement for Histomorphometry: Please provide specific dates of tetracycline administration.

First Label: Drug Name		Second Label: Drug Name	
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose
Date *(Month DD, YYYY)*	Dose	Date *(Month DD, YYYY)*	Dose

Telephone Consultation To:

Name	Phone

Report Sent To:

Name	Address - *(Street, City, State, ZIP)*

MML Use Only

Accession Number

MML Supply T352

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