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Appendix 2:

LAB NO:

Muscle Biopsy Request Form - Neuropathology

Level 1 West Wing, John Radcliffe Hospital, Headington, Oxford OX3 9DU

Enquiries: 01865 (2)34904 Email: oxford.neuropath@nhs.net

NB. This form replaces the standard Neuropathology Request Form

Put patient sticker here

Private: Yes / No

Consultant:

Date and time of biopsy:

Hospital where biopsy is taken:

Exact location of biopsy: deltoid R / L,
quadiceps R / L, other:

Essential Clinical Information (please answer all questions):

Consent for research? (please circle or write): YES / NO / UNABLE TO CONSENT

Risk of Infection? *Details*

Duration of symptoms (please write and circle): _____ (DAYS / MONTHS / YEARS)

Distribution of weakness (please circle or write): PROXIMAL / DISTAL / OTHER *Detail*

Other relevant symptoms and signs:

Presence of pain (please write and circle): YES / NO *Details:*

Past medical history:

Relevant medications:

Clinical Differential Diagnosis:

Tests Performed So Far:

Neurophysiology Result

Or NOT DONE / PENDING

Creatine kinase:

Date of Result

Requesting clinician's name with contact details:

Name of surgeon performing the biopsy with contact details:

NB. Any relevant clinic letters / further information should be attached to this form (this can be immensely helpful for reporting). Alternatively, the information should be emailed (oxford.neuropath@nhs.net) FAO muscle pathology service.

Reviewed by: Louise Young

E-Authorised by: Hannah Keyser

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Received	Date	Time
Tissue	Fresh	Fixed
Reporting pathologist		

Previous record	

Tissue preparation		
Cryostat		
EM		
SNAP		
SNAP/DNA		
SNAP/RCS		
Paraffin		
Tissue Culture		

Quality Assurance	BMS/CONS
Log In	
Sampling - fresh	
Sampling - fixed	
Embed	
Cryotomy	
Microtomy	
Slide check	
Typing	
E-Auth <input type="checkbox"/>	