

# Muscle Biopsy Referral Form

## Patient details

*Name:*  
*DOB:*  
*Gender:*  
*Contact number:*  
*Hospital No.*

## Referring clinician details

*Name:*  
*Contact number:*

### MRSA Status:

Swabs to be taken at time of decision to biopsy in outpatients

	YES	NO
Is the patient on antiplatelet agent eg. aspirin, clopidogrel?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient on anticoagulation therapy eg. warfarin?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a known bleeding tendency/risk?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had a previous adverse reaction to local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a transmissible disease?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient require sedation?	<input type="checkbox"/>	<input type="checkbox"/>
Is the proposed site safe and achievable for biopsy? (screen for varicose veins, oedema, gross wasting)	<input type="checkbox"/>	<input type="checkbox"/>

**Biopsy site: (Please TICK site)** *NB. Upper limb Bx must be referred to surgical teams*  
TA                      Quads                      Medial gastroc                      Lateral gastroc

## Sample request details

Samples for (tick box)	YES	NO
Histopathology	<input type="checkbox"/>	<input type="checkbox"/>
Mito Biochem+Histo	<input type="checkbox"/>	<input type="checkbox"/>
Mito DNA analysis	<input type="checkbox"/>	<input type="checkbox"/>
Skin Biopsy	<input type="checkbox"/>	<input type="checkbox"/>

## Clinical details/provisional diagnosis:

Previous histopathology numbers: .....  
CK Level: .....  
Drugs: .....

Email form to: [kerry.turnbull@nhs.net](mailto:kerry.turnbull@nhs.net)

Histopathology Laboratory No:

## Histopathology Request

## Muscle Biopsy Requests ONLY.

### Laboratory use only

Time Received .....

Assigned to.....

Typed by.....

Report Telephoned.....

Weight.....

Blocks processed.....

Issued PATH:

RVI  NGH  FH  DENTAL  OTHER

NHS  PRIVATE

Ward.....

Report to.....

Attach Addressograph:

	Biopsy Site/Nature of specimen
1.	
2.	
Time Taken	
Risk of infection: Y / N	
Details of infection:	

Consented storage/research : Y / N

Site of muscle biopsy: Open / Needle

### Samples sent to:

Histopathology

Mito Biochemistry/Histopathology

Mito DNA analysis

Report requested **URGENT** **ROUTINE**

(Muscle & Nerve Team **MUST** be contacted on 29133 prior to **URGENT** muscle biopsy requests)

Requested by.....(in capitals)

DECT No.....

Signature.....

Date.....

Time.....