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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@ouh.nhs.uk

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,
quadriceps R / L, other:

*** Purchase Order number (Required for all non OUH cases) ***

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@ouh.nhs.uk) FAO muscle pathology service.

THIS IS AN ACTIVE CONTROLLED DOCUMENT**LAB USE ONLY****Please ensure all fields below are filled in!**

Received	Date	Time
Tissue	Fresh	Fixed
Reporting pathologist		

Previous record	

Tissue preparation	Sample taken (✓)	Specify number of samples
EM		
SNAP		
SNAP/DNA		
SNAP/RCS		
Cryostat		
Paraffin		
Tissue Culture		

Quality Assurance	Staff Initials
Booked in	
Sampling – fresh	
Sampling – fixed	
Paraffin embedding	
Microtomy	
Cryotomy	
Slide check - paraffin	
Slide check - cryo	
Typing	
E-Authorised	