

THIS BOX IS
FOR EPISODE
NUMBER

CELLULAR PATHOLOGY MUSCLE/NERVE BIOPSY REQUEST

THIS BOX IS FOR
ACCESSION
NUMBER LABEL

Patient details: Use addressograph or fill in all fields		Consultant (Initial & Surname)
CRN:	M / F DOB	Hospital / Ward / Theatre
NHS No.		Address for report
Surname	Forename(s)	
Address		
Previous Biopsy: Y/N	Date of previous biopsy:	

Neurological History (including family history):

Differential Diagnosis

Clinical Recommendation of Site of Biopsy:

CPK Levels:..... Previous Steroid (immunosuppression) treatment Y / N

EMG/NC studies:.....

Inflammatory Markers

Other (please specify):... ..

Important co-morbidity, especially cardiac and respiratory

Current relevant medication :

FOR COMPLETION AT TIME OF BIOPSY:

Site of Biopsy :

Number of specimens sent:

Surgeon's Name (please print)	Bleep / Ext. No.	Date of biopsy	Time of biopsy

SHADED AREAS FOR LABORATORY USE ONLY

Specimen codes :						Date & Time received:
Received by:	Reporting pathologist:	Macro BMS:	Cryotomy by	Microtomy by:	Block check by:	Microscopy check by:

Further copies of this form are available from the Cardiff & Vale Cellular Pathology web site

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Consent for the Use of Muscle Biopsy Tissue to be Stored For Diagnostic and Research Studies

Apply demographic label/addressogram here

To have the best chance of reaching an accurate diagnosis some tissue from the muscle biopsy may be stored and some may need to be sent to other laboratories which undertake very specialised tests on muscle. These may include chemical molecular and DNA tests. While many of these tests are established in the NHS and are widely used for the diagnosis of muscle disorders, sometimes they are in a developmental or research stage: other tests may be developed in the future which could help in diagnosing your condition. If these are research tests, the laboratory doing the testing will have appropriate ethical approval for the procedure.

CONSENT FOR STORAGE AND RESEARCH STUDIES

I consent to allowing the muscle biopsy specimen to be stored for future diagnostic purposes and any residual tissue stored for appropriate research purposes relevant to my condition YES / NO

I agree that any residual sample can be used for the development of new disease tests and to understand more about the way in which disease develops YES / NO

I agree that any residual sample can be used for NHS staff education, training and performance monitoring purposes YES / NO

I agree that I can be contacted in the future if new NHS based tests are developed which might be of use to me or my family YES / NO

Signature of Patient:

Date:

I confirm that I have explained the above to the above patient and answered their questions to the best of my ability

Signature of consent taker:

Full Name in Capitals: **Date:**