**TEMPORAL ARTERY BIOPSY Referral Form**

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| **Patient details:** | **Referral made by:** |
| Name:      DOB:      Hospital No:      Address:      Postcode:      GP details:      GP Name:      Address:      **Tel./Mobile:**  | Name of referrer      Contact (bleep/email/other):      Referring consultant:       |
| **Time/Date of referral** | **Source of Referral:** |
| Date:       Time (24h clock)       | [ ] GP [ ] Rheumatology [ ] EAU [ ] OtherBMEC Eye A&E [ ]  |
| **Clinical Features** | **Brief History/Relevant Info/ clinical findings** |
|  Right LeftLoss of vision one eye [ ]  [ ] AION [ ]  [ ]  Retinal artery occlusion [ ]  [ ] Amaurosis fugax [ ]  [ ] Loss of visual field [ ]  [ ] New onset headaches [ ]  [ ] Temporal tenderness [ ]  [ ] Abnormal temp artery [ ]  [ ]  Jaw claudication [ ] Diplopia [ ]   |      Recent COVID contact [ ]  yes no [ ]  Dry cough [ ]  yes no [ ]  Fever [ ]  yes no [ ]  Loss of smell or taste [ ]  yes no [ ]  Abnormal chest x ray [ ]  yes no [ ]  Lymphopenia [ ]  yes no [ ]    |
| **Past medical history: ( tick all that apply)** | **Investigations**  |
| AF [ ]  Renal failure [ ] Hypertension [ ]  Pacemaker [ ] Angina [ ]  Diabetes [ ] MI [ ]  Heart failure [ ]   | Neutrophiles      Lymphocytes      Thrombocytes      ESR       CRP      Creatinine      CXR: Normal [ ]  / Abnormal [ ]  |
| **Current medications:** |  **Prednisolone started?**  |
| Warfarin / New anticoagulants (rivaroxaban etc)?  [ ]  yes no [ ]   | Dose      Date started       |
| **Patient location**  |
| Usual place of residence [ ]  | Aspirin 75 mg started ? [ ]  yes no [ ]   |
| Inpatient Ward [ ]   |  |
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