**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 Other  BMEC Eye A&E |
| **Clinical Features** | **Brief History/Relevant Info/ clinical findings** |
| Right Left  Loss 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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