**Temporal artery biopsy form**

Referred by:

Authorised by Rheumatology Consultant Yes No

Date of referral: Time of referral:

Name of patient

Hosp no DOB

Tel no

Presenting complaint:

Medications:

Referral letter on Lorenzo Yes No

New headache Yes No

Temporal artery abnormality (tenderness/reduced pulsation) Yes No

ESR >50 Yes No

Steroids started Yes No

Date of biopsy

Time of biopsy

Surgeon

Booked on Lorenzo Yes No