NHS No [ ][ ][ ] – [ ][ ][ ] – [ ][ ][ ][ ]

Hospital No | D.O.B.

Family Name

Title | First Name

No/Street

Tel. No. | Post Code

Sex M [ ] F [ ] | NHS [ ] | Private Patient [ ] | Category II [ ]

Requesting Location

Additional Copies To:

- [ ] Antenatal Group and Blood Group Antibody Screen

EDD / / Gravida........ Para........

- [ ] ✗ If previously transfused
- [ ] Kleihauer Delivery Date / / Time

- [ ] Group, Antibody Screen & Save
- [ ] DCT
- [ ] X-MATCH..................Units of Blood
- [ ] ISSUE OTHER BLOOD PRODUCTS specify:

Date Required / / Time

- [ ] FBC
- [ ] Sickle/Thalassaemia screen* — *Please state family origin
- [ ] *(Urgent Pre-op)
- [ ] ESR
- [ ] I M Screen
- [ ] INR
- [ ] APTR
- [ ] HbA_1C

Please ✗ if pt. on

- [ ] Warfarin or
- [ ] Heparin therapy

- [ ] ANA — **Require separate sample**

- [ ] U&E
- [ ] Glucose
- [ ] Bone Profile
- [ ] Renal Profile
- [ ] Initial Patient Assessment
- [ ] Cardiac Enzymes
- [ ] Liver Function Tests
- [ ] Thyroid Function Tests
- [ ] Fasting Lipid Profile
- [ ] Cholesterol
- [ ] Iron Studies
- [ ] B12 & Folate

- [ ] Therapeutic Drug Monitoring (including Antibiotics)

Please state drug(s) to be tested in "ANY OTHER TESTS", below
Please indicate the following in CLINICAL INFORMATION
Reason for request (e.g. toxicity, therapeutic confirmation)
Dose, dosage interval, time of last dose & how long on this dose
All other drug therapy Patient weight (kg)

- [ ] Routine Culture (MC&S)
- [ ] Mycology
- [ ] *Respiratory/Virus Antibody Screen
- [ ] Mycobacteria (AFB)
- [ ] Parasitology
- [ ] Syphilis Antibodies
- [ ] Antenatal Serology (HBsAg, HIV, rubella & syphilis antibodies)

- [ ] Rubella
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] *Hepatitis C

Please also tick box with reason for test

- [ ] *Suspected case
- [ ] *Contact
- [ ] Immunity Screen

*Date of Contact / / *Onset of Symptoms / /

Requests for viral/bacterial serology require a separate blood sample

- [ ] Virus Culture
- [ ] Chlamydia
- [ ] Respiratory Virus Immunofluorescence

- [ ] Non Cervical Cytology — **Requires separate sample**
- [ ] Histology

ANY OTHER TESTS

COLLECTION DATE

TIME

Collected by:

Blood sample collection
Monday - Friday
RBH 08:30 - 16:15
Newbury 08:30 - 15:30

SAMPLE TYPE

PLEASE USE A SEPARATE REQUEST FORM FOR EACH SAMPLE TYPE

- [ ] ✗ If fasting

CLINICAL INFORMATION

PLEASE INCLUDE DIAGNOSIS, DRUG THERAPY AND ANY SURGICAL PROCEDURE

LMP / /
EDD / /

*FAMILY ORIGINS
Patient:
Partner:

Authorising Doctor/
Nurse Practitioner (Please print)

....

Bleep No.....................

If urgent, phone Department and either ring this box or affix "URGENT" sticker here

NHS Royal Berkshire NHS Foundation Trust - Pathology Services Request Form Helpline Tel. 0118 322 7754 NHS

Review April 2013 Auth. D.Asplin

CSMF_GEN_request form
Created: February 08
Created by: Ann Halford