BLOOD SCIENCES REQUEST FORM AFFIX PRINTED PATIENT LABEL AFFIX PRINTED LOCATION LABEL * Denotes Mandatory Data Set LAB USE ONLY CHI Number* Return report to: Hospital/Practice SURNAME* Ward/Dept FORENAME* Consultant/GP PRIVATE Sex* M (circle) F Requestor Bleep/Tel SPECIMEN DETAILS INVESTIGATIONS REQUIRED Date collected / / ☐ U & E, Creatinine ☐ FBC ☐ INR Warfarin Therapy Liver group Time collected: (24hr) □ APTT Heparin Therapy Random Glucose Specimen type: Coagulation Screen ☐ Fasting Glucose Urine 🗌 Blood Serum B,2 Folate □ PT (Liver Assessment) Other (please state): Additional tests (Please specify) Duration of Collection Volume (for lab use) CLINICAL DETAILS (Please indicate diagnosis, clinical details, drugs) Date of LMP (where appropriate): / / /

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CHI Number* Surname* Forename* Sex* M Post Private	Return report to: Hospital/Practice Ward/Dept Consultant/GP Requestor Bleep/Tel	LAD USE ONE!
SPECIMEN DETAILS Date collected / / U & E, Crea Liver group Specimen type: Blood Urine Fasting Glu Other (please state): SPECIMEN DETAILS U & E, Crea Liver group Random Gli Fasting Glu Serum B ₁₂ Additional tests	INVESTIGATIONS REQUIRED Itinine	
Duration of Collection	TAILS (Please indicate diagnosis, clinical details, drugs)	