BLOOD SCIENCES REQUEST FORM

AFFIX PRINTED PATIENT LABEL * Denotes Mandatory Data Set

CHI Number*

SURNAME*

FORENAME*

SEX* (circle) M F POST CODE PRIVATE ☐

AFFIX PRINTED LOCATION LABEL

Return report to:

Hospital / Practice ....

Ward / Dept ....

Consultant/ GP ....

Requestor .... Bleep/Tel ....

LAB USE ONLY

SPECIMEN DETAILS

Date collected / /

Time collected: (24hr)

Specimen type:

Blood ☐ Urine ☐

Other (please state):

Duration of Collection ....

Volume (for lab use) ....

INVESTIGATIONS REQUIRED

☐ U & E, Creatinine
☐ Liver group
☐ Random Glucose
☐ Fasting Glucose
☐ Serum B_{12} ☐ Folate

☐ FBC
☐ INR Warfarin Therapy
☐ APTT Heparin Therapy
☐ Coagulation Screen
☐ PT (Liver Assessment)

Additional tests (Please specify)

CLINICAL DETAILS (Please indicate diagnosis, clinical details, drugs)

Date of LMP (where appropriate): .... / .... / ....

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