

NHS GG & C

BIOCHEMISTRY & HAEMATOLOGY REQUEST FORM



Please affix addressograph label below		Provisional Diagnosis & Clinical Summary: (*inc. therapy)
CHI NUMBER: _____ SURNAME: _____ FORENAME: _____ D.O.B. _____ SEX: M <input type="checkbox"/> F <input type="checkbox"/> Preg. <input type="checkbox"/> ADDRESS: _____ GP: _____ GP PRACT No: _____ Specimen taken by: _____		
Specimen Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Specimen CSF <input type="checkbox"/> Marrow <input type="checkbox"/> Fluid (State type) _____		Is patient fasting? Yes <input type="checkbox"/> Is patient on thyroxine? Yes <input type="checkbox"/>
Date: _____	Time (24hr clock): _____	HIGH RISK? _____
GEL TUBE (OCHRE)		
U&E	<input type="checkbox"/>	LAB USE ONLY
LFT	<input type="checkbox"/>	
BONE	<input type="checkbox"/>	
OTHER GEL TUBE (OCHRE) TEST		
FLUORIDE TUBE (GREY)		
GLUCOSE	<input type="checkbox"/>	LAB USE ONLY
OTHER FLUORIDE TUBE (GREY) TEST		
EDTA TUBE (PURPLE)		
FBC	<input type="checkbox"/>	LAB USE ONLY
ESR	<input type="checkbox"/>	
GFST	<input type="checkbox"/>	
OTHER EDTA TUBE (PURPLE) TEST		
CITRATE TUBE (BLUE)		
COAG SCREEN	<input type="checkbox"/>	LAB USE ONLY
INR	<input type="checkbox"/>	
OTHER CITRATE TUBE (BLUE) TEST		
OTHER SAMPLE TYPE		
OTHER SAMPLE TYPE TESTS		LAB USE ONLY