

**Patient Details (Complete Fully OR Attach an Addressograph Label inside the dotted line below):**

Surname

First Name  Male  Female

Date of Birth  /  /  Ethnicity (if relevant)

Patient's Address:

Doctor's Name  Practice address or practice stamp here  Practice Telephone Number:

Doctor's SJH Lab Code

Doctor's Signature

M.C.R.N.

*This is mandatory to ensure the doctor can be contacted during routine laboratory working hours 8am to 8pm.*

**Clinical Details / Drug Therapy:**

**GROUP 1 – (Blood) CLOTTED (Red)** \*\* Please state time of last dose below

<input type="checkbox"/> Renal Profile	<input type="checkbox"/> Creatine Kinase	<input type="checkbox"/> Lithium** ( <input type="text"/> )
<input type="checkbox"/> Liver Profile	<input type="checkbox"/> Lactate Dehydrogenase	<input type="checkbox"/> Digoxin** ( <input type="text"/> )
<input type="checkbox"/> Bone Profile	<input type="checkbox"/> PSA	<input type="checkbox"/> Phenytoin** ( <input type="text"/> )
<input type="checkbox"/> Amylase	<input type="checkbox"/> Prolactin	<input type="checkbox"/> Valproate** ( <input type="text"/> )
<input type="checkbox"/> Magnesium	<input type="checkbox"/> SHBG	<input type="checkbox"/> Theophylline** ( <input type="text"/> )
<input type="checkbox"/> Urate	<input type="checkbox"/> Progesterone	<input type="checkbox"/> Phenobarbitone** ( <input type="text"/> )
<input type="checkbox"/> CRP	<input type="checkbox"/> Oestradiol	<input type="checkbox"/> Carbamazepine** ( <input type="text"/> )
<input type="checkbox"/> Lipid Profile	<input type="checkbox"/> Cortisol	<input type="checkbox"/> CA 125
<input type="checkbox"/> Iron Studies	<input type="checkbox"/> HCG	
<input type="checkbox"/> LH & FSH	<input type="checkbox"/> TFT's (FT4 + TSH)	
<input type="checkbox"/> Vitamin D	<input type="checkbox"/> NT-pro-BNP (Chronic Disease Management)	

<p><b>GROUP 2 – (Blood) EDTA (Purple)</b></p> <input type="checkbox"/> Haemoglobin A1c	<p><b>GROUP 7 – (Blood) CLOTTED (Red)</b></p> <input type="checkbox"/> Connective Tissue disease Screen <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> IgG, A, M & Protein Electrophoresis <input type="checkbox"/> Thyroid Microsomal Ab (TPO) <input type="checkbox"/> Tissue Transglutaminase Ab <input type="checkbox"/> Anti-CCP <p><b>IgE Sensitization Tests</b></p> <p>A <b>Maximum of 3</b> of the specific IgE tests below can be ordered, based on History:</p> <input type="checkbox"/> Animal Danders <input type="checkbox"/> Peanut <input type="checkbox"/> House Dust Mite <input type="checkbox"/> Mixed Grass <input type="checkbox"/> Faecal Occult Blood (FOB)	<p><b>GROUP 8 – (Blood) EDTA (Purple)</b></p> <input type="checkbox"/> FBC <input type="checkbox"/> ESR <input type="checkbox"/> Infectious Mononucleosis Screen <input type="checkbox"/> Malaria Screen <b><i>You must Contact the Lab. on 4103843 before sending specimens for Malaria Screen.</i></b> <p><b>GROUP 9 – (Blood) CLOTTED (Red)</b></p> <input type="checkbox"/> Vitamin B12 / Serum Folate <sup>††</sup> <sup>††</sup> A fasting sample is required <input type="checkbox"/> Ferritin <p><b>GROUP 10 – (Blood) EDTA (Purple)</b></p> <input type="checkbox"/> G6PD Screen <input type="checkbox"/> Sickle Cell / Thalassaemia Screen* <i>* A Serum Ferritin is also required.</i>
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<p><b>GROUP 6 – (Blood) CLOTTED (Red)</b></p> <input type="checkbox"/> Testosterone <input type="checkbox"/> Androstenedione	<p><b>Other Tests:</b></p> <input type="text"/>	<p><b>For Laboratory Use Only</b></p> <p><b>Please record any extra specimens received.</b></p> <p>Serum    <input type="checkbox"/>    EDTA    <input type="checkbox"/>          Citrate    <input type="checkbox"/>    Glucose    <input type="checkbox"/></p>
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##### A separate specimen is required for tests in each of the above groups 1 to 10. #####  
 ##### All analyses may not be completed if there is an insufficient number of specimens provided. #####

Date Taken:  Time Taken:  Date/Time Received: