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| **Haematology Laboratory Request Form**  clear James logo (2)  **Vitamin B12/Folate Request Form**  **LabMed Directorate, St James’s Hospital, Dublin 8**  **Tel.: 01-416 2012 www.stjames.ie** | ***FOR SJH LABORATORY USE ONLY. PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE*** |

**All sections of this form MUST be completed by the requesting medical team.**

**Samples will not be analysed unless a fully completed form accompanies the samples.**

**Patient Information or Addressograph**

**\**1 separate Serum sample required\****

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB::\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_

Date and time of collection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Requester’s details:**  General Practitioner name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Address/Stamp:  SJH LAB CODE: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_  Doctors signature: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MRCN: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mandatory Request Information**   1. Is the request related to monitoring response to treatment? YES / NO (circle as appropriate)   If YES, please specify when the last sample was analysed? \_\_\_\_/\_\_\_/20\_\_\_\_\_\_  **NB: Serum Vitamin B12 and Folate levels should NOT be retested earlier than 3 months following commencement of supplementation or change in dose. Samples breaching this rule will be discarded.**   1. Is the request related to one or more of the following conditions (provide specific details)  * Abnormal FBC? (Please specify e.g., anaemia, macrocytosis, cytopenia) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * Any of the following: Suspect Dietary Deficiency, Suspect GI malabsorption, CNS disease, neuropathy, neuropsychiatric condition, monitoring deficiency, glossitis, pregnancy, alcoholism or hypothyroidism. (YES / NO (circle as appropriate)   **If YES**   * + **Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Please note that requests failing to meet the relevant criteria will not be processed**  All users received prior notification by GP Letter issued on 16.09.25 *(HAEM Memo 2025/07)* |
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| **Date and time of receipt in laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Request reviewed by Haematology team (Initials & Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**SJH Laboratory number**