



## BIOCHEMISTRY MANDATORY VITAMIN D REQUEST & CLINICAL INDICATION FORM

Down load from [www.stjames.ie](http://www.stjames.ie) OR google St James's LabMed user guide GP REQUEST FORMS

**From 04/11/2024, if this form is incomplete or not enclosed with the sample, Vitamin D testing will NOT proceed and the sample will be discarded**

**NB:** Routine screening of asymptomatic adults (including pregnant women) for Vitamin D deficiency is **NOT** currently recommended. Please do **NOT** request this test if the patient is not in the subgroup of individuals considered at risk of Vitamin D deficiency (see HSE <https://www.hse.ie/eng/about/who/cspd/lsr/resources/indications-for-measurement-of-vitamin-d-levels.pdf> and LabMed User guide for clarification)

### Patient Information or Addressograph

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

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

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

Hospital No. \_\_\_\_\_

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

**SJH Laboratory number**

### 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 Vitamin D treatment? YES / NO (circle as appropriate)

If YES, please specify when the last sample was analysed? \_\_\_\_/\_\_\_\_/20\_\_\_\_

**NB: Serum 25OH-D levels should NOT be retested earlier than 3 months following commencement of supplementation with Vitamin D or change in dose. Samples breaching this rule will be discarded.**

2. Is the request related to one or more of the following conditions (provide specific details)

- Metabolic Bone Disease? (Please specify) \_\_\_\_\_
- Biochemical findings related to abnormal Vitamin D levels e.g., increased alkaline phosphatase with otherwise normal liver function tests, hyperparathyroidism, hypo- or hypercalcaemia, hypophosphatemia. YES / NO (circle as appropriate)
  - If YES Please specify \_\_\_\_\_
  - When was the biochemical abnormality identified? \_\_\_\_/\_\_\_\_/20\_\_\_\_
- Other relevant medical conditions, medications or features that could be attributed to or lead to abnormal vitamin D status. 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 memo BIO-MEMO-2024/05 sent out on 16/07/24