# Test Request Form – [*name* laboratory]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient details** | | |  | **Requester details:** | |
| Name: |  | |  | Name: |  |
| Address: |  | |  | Organization |  |
| Telephone number: |  | |  | Address: |  |
| Date of Birth: |  | |  | Telephone number: |  |
| Gender: | Male | Female |  |  |  |

**Sample details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Urgency: | Normal |  | Sample taken from patient: | |
| URGENT | Date: | (dd/mm/yyyy) |
|  |  |  | Time: | (hh/mm) |
| Fasting | Non-fasting |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Blood  Faeces | Urine  Sputum | Swab  Fluids | Tissue  Cytology |
| Other, namely: |  |  |  |
|  |  |  |  |

**Relevant clinical information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug therapy: |  | Last dose: | |  |
|  |  | Date: | (dd/mm/yyyy) | |
|  | Time: | (hh/mm) | |
| Other relevant clinical information: |  | | | |
|  | | | |
|  |  | | | |

**Examination requested:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Profile test** | | **Biochemistry** | | **Hematology** | **Microbiology** | **Anatomical Pathology** |
| G2000  G 2000-X  GT9  GTI  NEO  ES  HB3 | DFS  LFT  RFT  TFT  MAC  LGL  LIP | CEA  CA 1  CA 5  CA 9  PSA  AFP  Glucose | HIV 1 & 2  HbA1c  HBsAg  H. pylori  Uric Acid  Free T4 | FBE (incl. ESR)  FBC  Hb  TWDC  Platelets  ABO & Rh (D)  Malaria parasites | Urine FEME  RPR (VDRL)  Microscopy/Culture/Sensitivity  AFB (ZN) Smear Only  AFB Smear & Culture | Histology  Non-Gynae/FNA  Site:   |  | | --- | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Additional tests:** | | | | **Cervical Cytology:** | | | | | | | |
|  | | | | Pap smear  Normal  Post-Mono Blood  Susp lesion | | | | | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | | Other: | | |  | | | |  |
|  | | | | Site | Cervix  Vault  Other, namely: | | | | | Endocx  Lat. Vag. Wall. | Post Fornix |
|  | | | |
|  | | | |
|  | | | | LMP | | (dd/mm/yyyy) | | | | |  |
|  | | | | Post – menopausal  HRT (hormone Replacement | | | | | | | |
|  | | | |
|  | | | | Other, namely: | | | |  | | | |
|  | | | |  | | | | | | | |
| **Date:** | **(dd/mm/yyyy)** |  | **Requester’s signature:** | | | | | |  | | |