Received: ___/___/_____

Test Request Form

Patient details

Name:
Address:
Telephone number:
Date of Birth:
Gender: Male Female

Requester details:

Name:	
Organization	
Address:	
Telephone number:	

Sample details:

Urgency: Normal
 URGENT

 Fasting Non-fasting

Sample taken from patient:
Date: (dd/mm/yyyy)
Time: (hh/mm)

 Blood Urine
 Faeces Sputum
 Other, namely:

 Swab Tissue
 Fluids Cytology

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

Additional tests:

Cervical Cytology:

 Pap smear
 Normal
 Post-Mono Blood
 Susp lesion
 Other:
Site Cervix Endocx Post Fornix
 Vault Lat. Vag. Wall.
 Other, namely:
 LMP (dd/mm/yyyy)
 Post – menopausal
 HRT (hormone Replacement
 Other, namely:

Date: **(dd/mm/yyyy)** **Requester's signature:**