

HAVE YOU LABELLED THE SPECIMEN CORRECTLY?

**PRESS FIRMLY ON EACH END
TO ENSURE A LEAKPROOF
SPECIMEN CARRIER**

JB:105348



BIOHAZARD

G.P. REQUEST FORM



BIOHAZARD
TEAR

**MATER MISERICORDIAE UNIVERSITY HOSPITAL
ECCLES STREET, DUBLIN 7, IRELAND**

G.P. REQUEST FORM
ALL SECTIONS MUST BE COMPLETED

PATHOLOGY LABORATORY
MF-GEN-020 Edition 1.07, 08/2018

MRN (If available)												Doctor's Name	Specimen Type:
Surname												Doctor's Address	Fasting <input type="checkbox"/> Hours <input type="text"/>
First Forename												Date / /	Time Taken : :
Patient's Address												MUST ALSO BE RECORDED ON SAMPLE	
D.O.B												Emergency Phone No. (For critical reports)	
Gender M <input type="checkbox"/> F <input type="checkbox"/>												Urgent Request <input type="checkbox"/>	
<p align="center">APPOINTMENTS FOR BLOOD TESTING Book on line @ Mater.ie</p> <p align="center">ILLEGIBLE TEST REQUESTS WILL NOT BE ACTED ON</p>													

Biochemistry / Endocrinology	Haematology	Immunology	Microbiology
<input type="checkbox"/> Renal <input type="checkbox"/> Liver <input type="checkbox"/> Bone <input type="checkbox"/> Lipid profile Fasting (min 12hr fast) <input type="checkbox"/> Lipid profile Non Fasting <input type="checkbox"/> Glucose Fasting <input type="checkbox"/> Glucose Non Fasting <input type="checkbox"/> HbA1c <input type="checkbox"/> ACR (Spot Urine) <input type="checkbox"/> TFT <input type="checkbox"/> B12 <input type="checkbox"/> Folate <input type="checkbox"/> Ferritin	<input type="checkbox"/> FBC <input type="checkbox"/> ESR <input type="checkbox"/> INR (Warfarin) <input type="checkbox"/> Coag Screen <input type="checkbox"/> Infectious Mononucleosis Screen <input type="checkbox"/> Retics <input type="checkbox"/> Malarial screen (patients must attend MMUH phlebotomy with completed malaria form available on Mater.ie)	Separate sample required for Immunology & one sample ONLY needed Antibodies to:- <input type="checkbox"/> TTG (Coeliac Screen) <input type="checkbox"/> Streptolysin - O (ASOT) <input type="checkbox"/> PCA <input type="checkbox"/> SMA <input type="checkbox"/> AMA <input type="checkbox"/> Anti Nuclear Antibody (ANA) <input type="checkbox"/> Rheumatoid Factor (RF) <input type="checkbox"/> CCP <input type="checkbox"/> Immunoglobulins Incorporating Electrophoresis	Urine <input type="checkbox"/> C/S <input type="checkbox"/> Pregnancy Sputum <input type="checkbox"/> C/S <input type="checkbox"/> TB Stools <input type="checkbox"/> C/S <input type="checkbox"/> O/P *Clinical details essential <input type="checkbox"/> Occult Blood Swab <input type="checkbox"/> C/S <input type="checkbox"/> MRSA Screening <input type="checkbox"/> HVS for Bacterial Vaginosis / Thrush <input type="checkbox"/> Gonorrhoea culture** (HVS unsuitable) **Please state site

Any Other Tests

FOR QUALITY AND PATIENT SAFETY, ALL TESTS SHOULD BE ORDERED ON HEALTHLINK

PLACE SPECIMEN IN BAG
REMOVE COVERING STRIP FOLD TOP OVER TO SEAL

BAG

FOLD

G.P. REQUEST FORM

1st proof