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 ☐ Swab ☐ Tissue
☐ Faeces ☐ Sputum ☐ Fluids ☐ 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 ☐ 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:** _____