OneWelbeck
Lung Health

OneWelbeck Lung Health - Pathology Request Form

Please complete all sections of the form. By completing this form, you confirm you have the consent required to share this information.

PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

DATE OF BIRTH: GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

CLINICAL INFORMATION

CLINICAL DETAILS / PROVISIONAL DIAGNOSIS: NOTES:

PRIORITY :

INFECTION STATUS:

BLOOD TESTS:

☐FBC	☐LFT	☐OESTRADIOL	☐NT-ProBNP	☐Immunoglobulin Profile	Other Tests:
☐ESR	☐LIPIDS	☐PROGESTERONE	☐TROPONIN T	☐Immunoglobulin E	
☐COAG SCREEN	☐BONE PROFILE	☐TESTOSTERONE	☐CK	☐Caeruloplasmin Level	
☐D-DIMER	☐CRP	☐PROLACTIN	☐AFP	☐ANA	
☐INR	☐HbA1c	☐SHBG	☐PSA	☐ANCA	
☐VIT B12 & FOLATE	☐GLUCOSE	☐CORTISOL	☐LDH	☐AMA	
☐FERRITIN	☐TFT	☐AMYLASE	☐CA125	☐Anti-LKM-1	
☐U & E	☐T3	☐FSH	☐CA15-3	☐Free Copper Level	
☐VIT D	☐IRON STUDIES	☐LH	☐CA19-9	☐A1AT	

PROFILES:

☐LH - STARDARD PROFILE	☐ALLERGY SCREEN 1 (Common Inhalants)	Specific Profiles: Please list:	Specific Allergens: Please list:
☐LH - BRONCHIECTASIS	☐ALLERGY SCREEN 2 (Common Foods)		
☐LH - BROCHOSCOPY			
☐LH - ILD			
☐LH - COPD			
☐LH - VASCULITIS			
☐LH - TB SCREEN			
☐LH - AEROALLERGEN SCREEN			

OTHER TESTS:

☐Hepatitis Acute Screen	☐Hepatitis D By PCR	☐MCU (Urine)	Specimen and site:
☐Hepatitis B DNA By PCR	☐Hepatitis D RNA By PCR	☐MRSA	Time:
☐Hepatitis C Genotype	☐Hepatitis D Virus	☐STD PCR Urine	Date:
☐Hepatitis A	☐Hepatitis Delta Antigen	☐COVID PCR	Is patient receiving antibiotics?
☐Hepatitis A immunity (IgG)	☐Hepatitis E IgG	☐Enteric Organism Detection PCR	☐ YES ☐NO
☐Hepatitis A immunity (Total)	☐Hep C Quantitative RNA/PCR	☐H Pylori Stool Antigen	If yes, please specify:
☐Hepatitis A IgM	☐EBV (Epstein-Barr)	☐Calprotectin Level	
☐Hepatitis B Profile	☐CMV (Cytomegalovirus IgM	☐FIT	Travel history:
☐Hepatitis B (HBeAg)	☐Wilson Gene Mutation	☐Elastase Level	
☐Hepatitis C IgG	☐HFE (Hemochromatosis Gene)	☐OCP	

REFERRER DETAILS

GP/REFERRER NAME : GP/REFERRER PRACTICE :

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient	☐ Bill to Insurer	☐ Bill to Embassy	☐ Bill to referrer
	INSURANCE COMPANY:	EMBASSY:	AGENCY NAME:
	MEMBERSHIP NO:	LETTER OF GUARANTEE: ☐ (Please attach)	
	AUTHORISATION CODE:		

NAME : SIGNED : DATE :

PROFESSIONAL REG NO:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form and submit to us via one of the following:

E: bookings.diagnostics@onewelbeck.com **A:** OneWelbeck Imaging & Diagnostics, 1 Welbeck Street, London W1G 0AR **T:** +44 (0)20 3653 2001