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:

MRN:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female ☐ Prefer not to say

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

CLINICAL INFORMATION

CLINICAL DETAILS / PROVISIONAL DIAGNOSIS: **NOTES:**

PRIORITY:

INFECTION STATUS:

BLOOD TESTS:

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

PROFILES:

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

OTHER TESTS:

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

REFERRER DETAILS

GP/REFERRER NAME: GP/REFERRER PRACTICE:

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

TYPE: ☐ Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)

INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:

EMBASSY: LETTER OF GUARANTEE: ☐ Yes (please attach)

NAME: SIGNED: DATE:

PROFESSIONAL REG NO:

Please attach any additional documentation to this form & submit to us via one of the following:
E: bookings.diagnostics@onewelbeck.com
A: Bookings, OneWelbeck Imaging and Diagnostics, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 6532001