

# 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say	
RESIDENTIAL ADDRESS:	POSTCODE:	
TELEPHONE:	MOBILE:	
EMAIL:		

## CLINICAL INFORMATION

CLINICAL DETAILS / PROVISIONAL DIAGNOSIS:	NOTES:
PRIORITY:	
INFECTION STATUS:	

### BLOOD TESTS:

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

<input type="checkbox"/> LH - STANDARD PROFILE <input type="checkbox"/> LH - BRONCHIECTASIS <input type="checkbox"/> LH - BROCHOSCOPY <input type="checkbox"/> LH - ILD <input type="checkbox"/> LH - COPD <input type="checkbox"/> LH - VASCULITIS <input type="checkbox"/> LH - TB SCREEN <input type="checkbox"/> LH - AEROALLERGEN SCREEN	<input type="checkbox"/> ALLERGY SCREEN 1 (Common Inhalants) <input type="checkbox"/> ALLERGY SCREEN 2 (Common Foods)	Specific Profiles: Please list	Specific Allergens: Please list
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### OTHER TESTS:

<input type="checkbox"/> Hepatitis Acute Screen <input type="checkbox"/> Hepatitis B DNA By PCR <input type="checkbox"/> Hepatitis C Genotype <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis A immunity (IgG) <input type="checkbox"/> Hepatitis A immunity (Total) <input type="checkbox"/> Hepatitis A IgM <input type="checkbox"/> Hepatitis B Profile <input type="checkbox"/> Hepatitis B (HBeAg) <input type="checkbox"/> Hepatitis C IgG	<input type="checkbox"/> Hepatitis D By PCR <input type="checkbox"/> Hepatitis D RNA By PCR <input type="checkbox"/> Hepatitis D Virus <input type="checkbox"/> Hepatitis Delta Antigen <input type="checkbox"/> Hepatitis E IgG <input type="checkbox"/> Hep C Quantitative RNA/PCR <input type="checkbox"/> EBV (Epstein-Barr) <input type="checkbox"/> CMV (Cytomegalovirus IgM) <input type="checkbox"/> Wilson Gene Mutation <input type="checkbox"/> HFE (Hemochromatosis Gene)	<input type="checkbox"/> MCU (Urine) <input type="checkbox"/> MRSA <input type="checkbox"/> STD PCR Urine <input type="checkbox"/> COVID PCR <input type="checkbox"/> Enteric Organism Detection PCR <input type="checkbox"/> H Pylori Stool Antigen <input type="checkbox"/> Calprotectin Level <input type="checkbox"/> FIT <input type="checkbox"/> Elastase Level <input type="checkbox"/> OCP	<b>Specimen and site:</b> <b>Time:</b> <b>Date:</b> <b>Is patient receiving antibiotics?</b> <b>Yes/No</b> <b>If yes, please specify:</b> <b>Travel history:</b>
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## 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: <input type="checkbox"/> 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](mailto:bookings.diagnostics@onewelbeck.com)

A: Bookings, OneWelbeck Imaging and Diagnostics, 1 Welbeck Street London W1G 0AR

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