OneWelbeck
Imaging & Diagnostics

Pathology Referral 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:

SPECIMEN TYPE: ☐ EDTA ☐ SST ☐ Citrate ☐ Lith hep ☐ Fluoride ☐ Plain

DATE & TIME OF COLLECTION:	PRIORITY:
PHLEBOTOMIST:	INFECTION STATUS:

BLOOD SCIENCES:

☐ Bone profile ☐ Electrolytes ☐ Urea, creatinine ☐ LFT ☐ Thyroid function tests (FT4 + TSH) ☐ Thyroid antibodies ☐ Free T3	☐ Lipids (Fasting glucose, cholesterol, HDL, iLDL triglyceride) ☐ Glucose ☐ Glycated Hb ☐ Urine alb/creat ratio ☐ Cortisol am/pm	☐ FBC ☐ Coagulation screen ☐ INR ☐ CK, AST, LDH ☐ Troponin I ☐ BNP ☐ B12 serum & red cell folate ☐ Fe & TIBC ☐ Ferritin ☐ Calcium	☐ CRP ☐ ESR ☐ Amylase ☐ Vitamin D ☐ PTH ☐ Prolactin ☐ Oestradiol ☐ FSH ☐ LH ☐ Testosterone ☐ SHBG	☐ AFP ☐ PSA ☐ LDH ☐ CA125 ☐ CA15-3 ☐ CA19-9 ☐ beta-hCG	☐ Immunoglobulins ☐ Serum free light chains ☐ BJP screen ☐ Monospot ☐ Sickle cell screen ☐ Hb electrophoresis

IMMUNOLOGY:

☐ Autoantibody profile (ANF, SMA, GPC, TPO, TGLB, LKMA, TTGT, AMA) ☐ ENA screen (SSA, SSB, Sm, RNP, SCL70, Jo1)	☐ ANCA ☐ GBM antibodies ☐ Rheumatoid factor ☐ Anti-CCP	☐ Allergy screen 1 (common inhalants) ☐ Allergy screen 2 (common foods)	☐ IgE ☐ Specific allergens: Please list ☐ Coeliac screen (TTG, Gliadin, IgA, EMA) ☐ C3 & C4

MICROBIOLOGY:

☐ MC&S ☐ TB ☐ Fungal culture ☐ MRSA screen only ☐ C. difficile toxin ☐ Virus by PCR (please specify)	☐ Hepatitis A (IgG, IgM) ☐ Hepatitis B sAg ☐ Hepatitis B markers ☐ Hepatitis B DNA ☐ Hepatitis B immunity	☐ RPR/TPHA ☐ HIV ☐ HBV DNA viral load ☐ HCV RNA viral load	Specimen and site: Time: Date: Is patient receiving antibiotics? Yes/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:
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A: Bookings, OneWelbeck Imaging and Diagnostics, 1 Welbeck Street London W1G 0AR
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