

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: <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:

SPECIMEN TYPE: EDTA SST Citrate Lith hep Fluoride Plain

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

BLOOD SCIENCES:

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

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

<input type="checkbox"/> MC&S <input type="checkbox"/> TB <input type="checkbox"/> Fungal culture <input type="checkbox"/> MRSA screen only <input type="checkbox"/> C. difficile toxin <input type="checkbox"/> Virus by PCR (please specify)	<input type="checkbox"/> Hepatitis A (IgG, IgM) <input type="checkbox"/> Hepatitis B sAg <input type="checkbox"/> Hepatitis B markers <input type="checkbox"/> Hepatitis B DNA <input type="checkbox"/> Hepatitis B immunity	<input type="checkbox"/> RPR/TPHA <input type="checkbox"/> HIV <input type="checkbox"/> HBV DNA viral load <input type="checkbox"/> HCV RNA viral load	Specimen and site: Time: Date: Is patient receiving antibiotics? Yes/No If yes, please specify: Travel history:
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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:
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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