

All sections of this form must be fully completed

Cromwell Hospital, Cromwell Road, London SW5 0TU
Tel: 0207 460 2000 Fax: 0207 460 5555

Laboratory Direct Line: 0207 460 5565 or Freeset 7064
Laboratory Direct Fax: 0207 835 0361

Nursing Station/Room: _____

Surname

Date: _____ Time of Request: _____

Forenames

Clinician: _____

Authorising signature: _____ GMC Number: _____

Hospital No. DoB Sex M F

Clinical details including drug therapy: <input type="checkbox"/> Fasting <input type="checkbox"/> Pregnant <input type="checkbox"/> Ethnic Origin (Please specify) _____ <input type="checkbox"/> Post Menopause <input type="checkbox"/> Drug Therapy (Please specify) _____ <input type="checkbox"/> Post Natal	Results to be sent to: Email address: _____ Telephone number for urgent escalation (must be reachable 24hrs): _____
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Phlebotomist signature: _____ Collection Date: _____ Time: _____ Urgent

<p>CROMWELL HOSPITAL PROFILES</p> <input type="checkbox"/> CP1 Cromwell Full Blood Count Full Blood Count, 5 Part Diferential <input type="checkbox"/> CP2 Cromwell Haematology Profile Full Blood Count, 5 Part Diferential, ESR <input type="checkbox"/> CP3 Cromwell Biochemistry Profile Biochemistry, Lipids, Ferritin <input type="checkbox"/> CP4 Cromwell Haematology & Biochemistry Profile Full Blood Count, ESR, Biochemistry, Lipids, Ferritin <input type="checkbox"/> CP5 Cromwell Thyroid Profile FT3, FT4, TSH <input type="checkbox"/> CP7 Cromwell Outpatient Profile CP4, FT4, TSH, FT3 <input type="checkbox"/> CP10 Cromwell Cardiovascular Risk Profile CP4, hsCRP, Homocysteine, Fibrinogen, Lipoprotein (a) <input type="checkbox"/> CP12 Diabetic Profile Glucose, HbA1C, U/E's, Lipids, FT4/TSH/FT3	<input type="checkbox"/> Hepatitis A Profile <input type="checkbox"/> Hepatitis A, B, C Profiles <input type="checkbox"/> Hepatitis B Profile <input type="checkbox"/> Hepatitis B sAg <input type="checkbox"/> Hepatitis B sAb (immunity) <input type="checkbox"/> Hepatitis C Abs <input type="checkbox"/> Hepatitis C Viral Load <input type="checkbox"/> HIV I & II <input type="checkbox"/> HRT Profile <input type="checkbox"/> Iron Status Profile <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Liver Function Tests <input type="checkbox"/> MMR: Measles, Mumps, Rubella <input type="checkbox"/> Menopause Profile <input type="checkbox"/> Osteoporosis Screen <input type="checkbox"/> Ovarian Reserve Profile <input type="checkbox"/> Polycystic Ovary Syndrome Profile <input type="checkbox"/> Prostate Profile <input type="checkbox"/> Respiratory Viral Screen <input type="checkbox"/> Urea and Electrolytes Profile <input type="checkbox"/> Viral Antibody Screen <input type="checkbox"/> VDRL <input type="checkbox"/> TPHA <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 153 <input type="checkbox"/> CA 199 <input type="checkbox"/> CEA <input type="checkbox"/> AFP <input type="checkbox"/> 520992 Genetic - Lipid inCode CVD Genetic Profile FH, Poly-genic Risk, CHD Risk, Lp(a), Pharmacogenetics	<p>MICROBIOLOGY</p> <input type="checkbox"/> MSU m/c/s <input type="checkbox"/> Culture and Sensitivity Swab Site _____ <input type="checkbox"/> Culture and Sensitivity Fluid State Fluid Type _____ <input type="checkbox"/> Sputum Culture & Sensitivity <input type="checkbox"/> Blood Culture <input type="checkbox"/> TB Culture <input type="checkbox"/> Faeces m/c/s <input type="checkbox"/> Faeces OCP <input type="checkbox"/> Faeces Occult Blood (FOB) <input type="checkbox"/> HVS <input type="checkbox"/> Swab - state site: _____ <p>MRSA 1 Swab per site</p> <input type="checkbox"/> Culture and MRSA - on demand	<p>CERVICAL CYTOLOGY</p> <input type="checkbox"/> PAPT Thin Prep Cervical Cytology LMP: ___/___/___ Last smear: ___/___ MONTH YEAR <input type="checkbox"/> Routine screen <input type="checkbox"/> Colposcopy Previous abnormal: (please specify) _____ <input type="checkbox"/> HPVT Thin Prep HPV <input type="checkbox"/> PAP+HPV (Combined) <input type="checkbox"/> HPVT Thin Prep Chlamydia <input type="checkbox"/> TCG Thin Prep CT/NG combined <input type="checkbox"/> Pregnant <input type="checkbox"/> Irregular Bleeding <input type="checkbox"/> Post Menopause <input type="checkbox"/> Suspicious Cervix <input type="checkbox"/> Post Natal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> IUCD <input type="checkbox"/> HRT
		<p>Other tests (please specify):</p>	

	EDTA	ESR	GOLD	GREY	RED	L BL	D BL	MSU	FAEC	SWAB	PAP	24 HR	OTHERS
Sample date													