



# LIFEBRIDGE C. HOSPITAL

COMPREHENSIVE MENTAL HEALTH / REHABILITATION

Northern Bypass Roysambu

Behind Treat Hotel

Phone: 0725-133-444/0732-313-173

Email: lifebridgeke@gmail.com

## LABORATORY REQUEST AND REPORT FORM

**NOTE:** Incompletely filled forms will not be processed

### I. Patient Details

Name: .....

Age: (yrs/months).....

Sex : M ☐ F ☐

Residence/ Village.....

IP/OP No:.....

Report to(specify clinic/ward/clinician).....

II. Specimen:.....

III. Collection date/time...../...../.....

IV. Lab. No:.....

### II. Specimen Destination

Tick appropriate box

Blood bank

Histology/cytology ☐ Bacteriology ☐

Serology ☐ Parasitology ☐

Hematology/CD4 ☐ Biochemistry ☐

Others(specify)

.....

### V. Investigation requested:

### VI. History (including drugs used)

VII. Diagnosis.....

VIII. Requesting Clinician's Name.....

Signature..... Date...../...../.....

### IX. Report(including macroscopic examination);

Test done by (initial)..... Sign..... Date...../...../.....

Approved by (initial)..... Sign..... Date...../...../.....



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#### X. Patient Details

Name: .....

Age: (yrs/months).....

Sex : M ☐ F ☐

Residence/ Village.....

IP/OP No:.....

Report to(specify clinic/ward/clinician).....

#### II. Specimen Destination

Tick appropriate box

Blood bank

Histology/cytology ☐ Bacteriology ☐

Serology ☐ Parasitology ☐

Hematology/CD4 ☐ Biochemistry ☐

XI. Specimen:.....

Others(specify)

XII. Collection date/time...../...../.....

XIII. Lab. No:.....

XIV. Investigation requested:

XV. History (including drugs used)

XVI. Diagnosis.....

XVII. Requesting Clinician's Name.....

Signature..... Date...../...../.....

XVIII. Report(including macroscopic examination);

Test done by (initial)..... Sign..... Date...../...../.....

Approved by (initial)..... Sign..... Date...../...../.....

