Gilead Medical & Dental Centre

Branch _____

LABORATORY REQUEST FORM

Patient's ID No. _____ Date: dd / mm / yyyy

Patient's Full Name		
Address	Gender ☐ M ☐ F	Age

Medical Officer's Full Name	
Clinic/Hospital Name	Phone No.
Address	

Sample Details

☐ Blood ☐ Faeces ☐ Urine ☐ Sputum ☐ Swab ☐ Fluids ☐ Tissue ☐ Cytology

Other, Namely

Relevant Clinical Information

Drug Therapy	Last Dose Date: dd / mm / yyyy Time: hh / mm / ss
Other Relevant Clinical Information	

Examination Requested

Profile Test	Biochemistry	Hematology	Microbiology	Anatomical Pathology
☐ G2000 ☐ G 2000-X ☐ GT9 ☐ GTI ☐ NEO ☐ ES ☐ HB3 ☐ LFT ☐ RFT ☐ TFT ☐ MAC ☐ LGL ☐ LIP ☐ DFS	☐ CEA ☐ CA 1 ☐ CA 5 ☐ CA 9 ☐ PSA ☐ AFP ☐ Glucose ☐ HbA1c ☐ HBsAg ☐ H. Pylori ☐ Uric Acid ☐ Free T4 ☐ HIV 1 & 2	☐ FBE (incl. ESR) ☐ FBC ☐ Hb ☐ TWDC ☐ Platelets ☐ ABO & RH (D) ☐ Malaria Parasites	☐ Urine FEME ☐ RPR (VDRL) ☐ Microscopy/Culture /Sensitivity ☐ AFB (ZN) Smear Only ☐ AFB Smear & Culture	☐ Histology ☐ Non-Gynae/FNA Site:

Cervical Cytology	Additional Tests
☐ PAP Smear ☐ Normal ☐ Post-Mono Blood ☐ Susp Lesion ☐ Other ☐ LMP ☐ Post – Menopausal ☐ HRT (Hormone Replacement) Site ☐ Cervix ☐ Endocx ☐ Vault ☐ Lat. Vag. Wall. ☐ Post Fornix Other, namely:	

Medical Officer's Name _____

Signature & Stamp _____ Date: dd / mm / yyyy