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CLINICIAN

 Doctor \_\_\_\_\_  
 Address \_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_

**Please note: sample will NOT be processed until payment is received**
**Payment options**

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- On-account/Direct debit
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- Cheque
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- Please make cheques payable to Medlab Pathology Ltd
  - If clinics wish to sign up for Direct Debit, please contact our Finance Department on 1800 303 349
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- Credit/Direct Card
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- Please complete payment details at bottom of form

SURNAME																		DOB	/	/		
FORENAME											TITLE							M/F	When completing this form please provide at least three unique identifiers for your patient.			
Sample Date																						
										Sample Time												
											Patient Ref/ID No.											

**PROFILES AND TESTS** *Please specify*

- AMH Anti-Mullerian Hormone** B
- VITD Vitamin D** B
- UCTNG Chlamydia / Gonorrhoea** (Roche Urine Tube)
- EU1 EU1 Screen** (HIV, Hep B Surface Ag, Hep B Core Abs, Hep C Abs) B
- EU2 EU2 Screen** (HIV, Hep B Surface Ag, Hep B Core Abs, Hep C Abs, Syphilis Ab) B
- CALP Faecal Calprotectin** (Random Stool)
- FHP Female Hormone Profile** (FSH, LH, Oestradiol, Prolactin, Progesterone) B
- MHP Male Hormone Profile** (FSH, LH, Testosterone) B
- DL1 Biochemistry** B G
- DL1L Biochemistry plus HDL/LDL** B G
- DL2 Biochemistry and Haematology** B A G
- DL2L Biochemistry and Haematology plus HDL/LDL** B A G

**OTHER TESTS** *Please specify*


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TAP1679C/18-04-19/V4

For Practice Use Only:						For Laboratory Use Only:						Codes	
EDTA	SST	GREY	MSU	OTHERS	INITIALS	EDTA	SST	GREY	MSU	OTHERS	INITIALS		
													

**PAYMENT DETAILS: PLEASE ENSURE THIS SECTION IS COMPLETED PRIOR TO REFERRAL OF SAMPLES**

<b>Payment method:</b> <input type="checkbox"/> Debit card <input type="checkbox"/> Credit card	<b>Total amount: €</b> _____
<b>Cardholder name:</b> _____	<b>Card expiry date:</b> _____ / _____
<b>Card number:</b> _____	<b>CWV:</b> _____
<b>Cardholder signature:</b> _____	