PATIENT RECEPTION AT:
THE DOCTORS LABORATORY
76 Wimpole Street, London W1G 9RT
Monday to Friday 7.00am – 7.00pm
Saturday 9.00am – 5.00pm
Main Tel: 020 7307 7373
Patient Reception Fax: 020 7307 7371

Out of hours samples may be dropped at 76 Wimpole St

CLINICIAN

SOURCE

Doctor Name of requesting Doctor/Clinic
Address
Tel Fax

Additional copy of results to:
We will send copy results, on request to other doctor(s) or patient. Please provide name(s) and address details.

SURNAME	N A M E	DOB	DD / MM / YY
FORENAME	P A T I E N T	TITLE	MR
		M/F	MALE

When completing this form please provide at least three unique identifiers for your patient.

Patient Ref/ID No.

		Please Tick
(Biochemistry)	DL1	☐
(Biochemistry/HDL)	DL1L	☐
(Haem/Bio)	DL2	☐
(Haem/Bio/HDL)	DL2L	☐
(Haematology)	DL3	☐
(Haem/Bio (short))	DL4	☐
(Haem/Bio/HDL)	DL4L	☐
(Postal Haem/Bio)	DL5	☐
(Postal Haem/Bio/HDL)	DL5L	☐
Well Person Screen (DL2/T4/TSH/Ferritin)	DL6	☐
Well Person Screen (DL2L/T4/TSH/Ferritin)	DL6L	☐
Well Man Screen (DL6/PSA/Ferritin)	DL7	☐
Well Man Screen (DL6L/PSA/Ferritin)	DL7L	☐
Well Woman Screen (DL6/VITD/Ferritin)	DL8	☐
Well Woman Screen (DL6/HDL/VITD/Ferritin)	DL8L	☐
Senior Male Profile 60+	DL9M	☐
Senior Female Profile 60+	DL9F	☐
Cardiovascular Risk Evaluation Profile	DL10	☐
Cardiovascular Risk Plus Profile	DL11	☐
Sexual Health 7 STI screen by PCR	DL12	☐

ECG (Service available Mon-Fri between 9.00am and 4.00pm) ☐

Home Visit ☐

PATIENT DETAILS
LMP: / /
Last smear: / (MONTH YEAR)
Routine screen ☐
Colposcopy ☐
Previous HPV -ve ☐ +ve ☐
Previous abnormal history (please specify):

TESTS (PLEASE SPECIFY)
- **PAPT** Thin Prep Cervical Cytology ☐
- **HPV HR-HPV DNA** Collective reporting of HPV subtypes ☐
- **HP20 20 HPV DNA subtypes** (5 low risk, 15 high risk) ☐
- **HPVT Typed DNA/mRNA** HP20 with reflex mRNA for E6/E7 oncoprotein expression ☐
- **TPCR** Thin Prep Chlamydia ☐
- **TGON** Thin Prep Gonorrhoea ☐
- **TCG** Thin Prep CT/GC ☐
- **7 STI (DL12)** 7 STI Screen by PCR ☐

PROFILES AND TESTS
Please specify

Tick DL profiles, as required (see left) and list any other tests/profiles you require

TAP2324/10-11-14/V12

Clinical Details
☐ Fasting (tick if yes)
☐ Ethnic Origin (details, if relevant)
☐ Drug Therapy (Please specify)

☑ Fee to be paid by Patient/Other. **PLEASE PROVIDE ADDRESS DETAILS**

OR

Insurance Co. Membership No.
Patient address Patient's full address details, including postcode and telephone number
Postcode Contact telephone number

☑ Fee to be paid by Doctor/Clinic as above
Signature Signature
Date sample taken dd/mm/yy
Time sample taken hh : mm

For Practice Use Only:						For Laboratory Use Only:						For Patient Service's Use Only:			
EDTA	SST	GREY	MSU	OTHERS	INITIALS	EDTA	SST	GREY	MSU	OTHERS	INITIALS	TIME IN R	TIME IN Ph	TIME OUT Ph	TAKEN BY INITIALS

THE DOCTORS LABORATORY