PATIENT RECEPTION AT: THE DOCTORS LABORATORY 76 Wimpole Street, London W1G 9RT Monday to Friday 7.00am-7.00pm Saturday 7.00am-1.00pm Main Tel: 020 7307 7373			, Adding the second sec	OLINIGIAN									SOURCE	SOURCE		
			RT	Doctor									Additio	Additional copy of results to:		
				Address												
Out of hours samples may be dropped at 76 Wimpole St				Tel												
be dropped at 76 wimpole St Email																
SURNAME	IAME							DOB							When completing this form please provide at least three	
FORENAME							TITLE				M/F				unique identifiers for your patient	
								Pa	tient Re	ef/ID	No.					
TEST	TEST															
ENDT Ziwig Endotest Self-collect Endotest saliva collection kit																
ETTS I ETTING ETTACLOSE CONTROLLEGE ETTACLOSE SANVA CONECULOTI KIL												Please place Ziwig				
CLINICAL INFORMATION FOR ELIGIBILITY PROVIDED BY THE PATIENT																
Samples will be rejected if:													rcode here			
Your age is not within the specified range or you do not present clinical signs suggestive of andometrics is																
you do not present clinical signs suggestive of endometriosis • You have a history of cancer, or HIV, or are pregnant																
		-			-	.	Г	Vود		Jo.						
Are you aged between 18 and 43 years?																
(pelvic pain/infertility)?																
Do you have history of cancer (0059)?								☐ Yes ☐ No								
Do you have history of HIV (0060)?							☐ Yes ☐ No									
Are you pregnant (0061)?																
PRE-ANALYTICAL INFORMATION TO BE COMPLETED BY THE PATIENT																
Samples will be rejected if the answer is 'Yes' to any of the following questions																
In the 30 minutes prior to collecting my saliva sample, did you																
Eat?	,					, , , , , , , ,		Yes	N	No						
Smoke?								☐ Yes ☐ No								
Drink?								☐ Yes ☐ No								
Chew gum?								Yes	N	Vo						
Brush your teeth?								☐ Yes ☐ No								
Rinse your mouth?								Yes No								
Wear lipstick?																
Were you unwell (cold, etc.)? ☐ Yes ☐ No																
Did yo	Did you have bleeding from your mouth?															
												I	TAP5557/17-10-24/V2			
	Fee to be paid by Patient/Other. PLEASE PROVIDE ADDRESS DETAILS												ee to be paid by Doctor/Clinic as above			
Insurance Co. Membership No. Patient address										Signatu	ıre					
										ample taken						
Postcode		Contact	telephone			arlie - C	anh				Eou Devi	ont C	rvice's !!		ample taken	
	ice Use Only:	U OTHERS	INITIALS	For La	sst	y Use O	MSU	OTHER	S INI	TIALS	TIME IN	TIME I	rvice's Us			
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