PATIENT RECEPTION AT: THE DOCTORS LABORATORY							OLINICIAN											SOURCE								
76 Wimpole Street, London W1G 9RT Monday to Friday 7.00am-7.00pm Saturday 7.00am-1.00pm Main Tel: 020 7307 7373						Doctor Address											Additional copy of results to:									
Out of hours samples may be dropped at 76 Wimpole St							Tel Email																			
SURNAME															DOB M/F		/	/		р	is form st three ur patient					
FORENAME										111	Patient Ref/ID No.									a i i i			101 70	ur pationi		
TEST	TEST																									
	■ ENDT Ziwig Endotest Endotest saliva collection kit																									
CLIN	CLINICAL INFORMATION FOR ELIGIBILITY															Please place Ziwig										
	Samples will be rejected if:															barcode here										
the	Patient's age is not within the specified range or they do not present clinical signs suggesting endometriosis																									
	Patient has a history of cancer or HIV, or is pregnant      Delicable and between 40 and 40 areas 2.																									
Prese	Patient's age between 18 and 43 years?  Presence of clinical signs suggestive of endometriosis  Yes No																									
(pelvic pain/infertility)? History of cancer (0059)?								☐ Yes ☐ No ☐ Yes ☐ No																		
History of HIV infection (0060)?								☐ Yes ☐ No																		
Pregnant patient (0061)?										☐ Yes ☐ No																
PRE-	PRE-ANALYTICAL INFORMATION																									
Samp	Samples will be rejected if the answer is 'Yes' to any of the following questions																									
In the	In the 30 minutes prior to sampling, did the patient:																									
Eat?								☐ Yes ☐ No																		
Smoke?												Yes		No												
Drink?												Yes No														
Chew gum?												Yes														
Brush her teeth?									∐ Yes ☐ No																	
Is the	pati	ent w	earing	g lipstick	(?							Yes		No												
Is the	pati	ent ill	(cold,	, etc.)?								Yes		No												
Is the	re bl	eedin	g fron	n the m	outh	1?						Yes		No												
																			TAP5427B/01-08-24/V7							
Fe	ee to b	e paid	by Patie	ent/Other.	PLEA	SE PRO	VIDE AI	DDRESS	DETA	ILS									Fee to be paid by Doctor/Clinic as above							
																		_	Signature							
Patient address													Date sample taken													
Postcode Contact telephone number														_		ample	taken									
For Practice Use Only:  EDTA SST GREY MSU OTHERS INITIALS EDTA SST GREY MSU OTHERS INITIALS TIME IN TIME IN TIME OF THE INITIALS THE INITIAL										OUT	TAKEN B			_	_											
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