**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
***Out of hours samples may be dropped at 76 Wimpole St***

CLINICIAN

SOURCE

Doctor

Address

Tel

Email

Additional copy of results to:

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

## TEST

■ **ENDT Ziwig Endotest** **Self-collect Endotest saliva collection kit**

## REQUIRED INFORMATION FOR ELIGIBILITY PROVIDED BY THE PATIENT

Please place Ziwig barcode here

**Samples will be rejected if:**

- **Your age is not within 18 years and 43 years**
- **You have a history of cancer, or HIV, or are pregnant**
- **The saliva collection device is outside the use-by date**

| | | |
|---|---|---|
| Are you aged between 18 and 43 years? | ☐ Yes | ☐ No |
| Do you have clinical signs suggestive of endometriosis (pelvic pain/infertility)? | ☐ Yes | ☐ No |
| Do you have history of cancer (0059)? | ☐ Yes | ☐ No |
| Do you have history of HIV (0060)? | ☐ Yes | ☐ No |
| Are you pregnant (0061)? | ☐ Yes | ☐ No |

**Expiry date on tube checked? Date of expiry:** D D M M Y Y Y Y

## 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 | ☐ No |
| Smoke? | ☐ Yes | ☐ No |
| Drink? | ☐ Yes | ☐ No |
| Chew gum? | ☐ Yes | ☐ No |
| Brush your teeth? | ☐ Yes | ☐ No |
| Rinse your mouth? | ☐ Yes | ☐ No |
| Wear lipstick? | ☐ Yes | ☐ No |
| Were you unwell (cold, etc.)? | ☐ Yes | ☐ No |
| Did you have bleeding from your mouth? | ☐ Yes | ☐ No |

**I have confirmed that the use by date for the saliva collection device has been confirmed as within date**

TAP5557B/12-03-25/V3

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

Insurance Co. Membership No.

Patient address

Postcode Contact telephone number

☐ Fee to be paid by Doctor/Clinic as above

Signature _____

Date sample taken _____

Time sample taken _____

| 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