


SENDER:												DATE SPEC. TAKEN							
ADDRESS:												TIME SPEC. TAKEN							
PATIENT SURNAME:													SPECIMEN TYPE						
FIRST NAME:																			
CLINICAL DETAILS												HAZARD							
SEX: M / F		PREGNANT: Y / N				DATE OF BIRTH DD/MM/YY													
CONSULTANT				GP CODE:															
WARD / CLINIC												DRUG/ANTIBIOTIC THERAPY							
TEST(S) REQUESTED (Tick as required)						REASON FOR TEST						For Office Use Only							
FULL SCREEN		<input type="checkbox"/>				METHADONE PROTOCOL		<input type="checkbox"/>				CODE:							
OTHER		<input type="checkbox"/>				PROBATION / COURT		<input type="checkbox"/>				REQUESTING SIGNATURE (legible)							
PLEASE SPECIFY						OTHER (SPECIFY)		<input type="checkbox"/>											
DATE RECEIVED						DATE REPORTED												