

Referring Doctor		Doctor's Code	Doctor's NMA No.		URGENT <input type="checkbox"/>
Hospital & Ward		File Number		Contact Person:	
Patient Surname		Patient First Name		Please tick no. supplied (✓) Tel <input type="checkbox"/> Fax <input type="checkbox"/> Cell <input type="checkbox"/>	
Address / Postal Address					
Tel. (h)		Tel. (w)		Cell	E-mail
Date of Birth	D	M	Y	GENDER (✓) M <input type="checkbox"/> F <input type="checkbox"/>	
Company / Health Insurance					
Company I.D No. Health Insurance No.					
BILL PATIENT		BILL HOSPITAL		BILL COMPANY / HEALTH INSURANCE	

Relevant Clinical Data and Present Medication: LMP FASTING (✓) YES NO

Other Tests:

MICROBIOLOGY

<p>MUMC <input type="checkbox"/> URINE MICROSCOPY + CHEMISTRY</p> <p>MUR <input type="checkbox"/> URINE MC&S</p> <p>MFMIC <input type="checkbox"/> STOOL MICROSCOPY</p> <p>MFAE <input type="checkbox"/> STOOL MC&S</p> <p>MGMIC <input type="checkbox"/> SWAB MICROSCOPY</p> <p>MPUS <input type="checkbox"/> SWAB MC&S</p> <p style="text-align: center;">SITE</p> <p>MCMC <input type="checkbox"/> CSF CELLCOUNT + MICROSCOPY</p> <p>MCSF <input type="checkbox"/> CSF MC&S</p> <p>MBCNA <input type="checkbox"/> BLOOD CULTURE</p> <p>MSTD <input type="checkbox"/> SEMEN MC&S</p>	<p>MTBR <input type="checkbox"/> TB CULTURE ONLY</p> <p>MTBRS <input type="checkbox"/> TB CULTURE WITH SENSITIVITY</p> <p>MGAFB <input type="checkbox"/> ZN SMEAR (acid fast bacilli)</p> <p>MMKOH <input type="checkbox"/> FUNGAL MICROSCOPY</p> <p>MMCUL <input type="checkbox"/> FUNGAL CULTURE</p> <p>MGA <input type="checkbox"/> ASPIRATE MC&S</p> <p style="text-align: center;">SITE.....</p> <p>MSPT <input type="checkbox"/> SPUTUM MC&S</p> <p>1634 <input type="checkbox"/> CHLAMYDIA ANTIGEN</p> <p>4874 <input type="checkbox"/> BLOOD MICROSCOPY (parasites)</p> <p style="text-align: center;">SUSPECTED PARASITES.....</p>
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530 <input type="checkbox"/> Home <input type="checkbox"/>		FOR LABORATORY USE			
Collected by	Date	Received by	Logged by	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Location code	Time	Date	Time	Checked by	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40