Hospital Haematology/Clinical Biochemistry Request Form

University Hospitals Bristol NHS
NHS Foundation Trust

<< Use approved patient ID label here

Hospital

Hospital Number

Surname

Forename

Date of birth

Sex (M or F)

Ward or location

Consultant

Requesting Clinician

Bleep no. _____

Sample date (ddmm)

Time (24 hr clock)

Clinical details/therapy

Other blood tests

Also comments that require action by laboratory (eg Urgent, Inoculation Risk)

Sample or Fluid Type

(Do not use form for Antibiotics, Bacteriology, Virology & Antenatal)

Profile code (see overleaf)

EDTA (purple)

- FBC
- Plasma viscosity
- Sickle cell/thal
- HbA1c
- Malaria screen

SST (yellow)

- ANCA
- Autoimmune
- Glandular fever
- RA test

Citrate (light blue)

- Clotting screen
- INR for warfarin control
- aPTTr for IV heparin control
- D-dimer

Random urine

- Drugs of abuse
- Microalbumin

SST (yellow)

- U&E and Creatinine
- Glucose — X if fasting
- LFT
- Cholesterol
- Lipid profile — X if fasting
- Calcium
- CRP
- Ferritin
- B12 & Folate
- Troponin I
- TFT — X if on T4
- Progesterone
- FSH
- LH — Day of cycle

Fluoride (grey)

- Glucose — X if fasting

Please indicate the tests required with a cross (X) and write in CAPITALS contained within the boxes.

UBHT - Hospital 'Cellular Pathology' Request Form

<< Use approved patient ID label here

Hospital

Hospital Number

Surname

Forename

Date of birth

Gender (M,F or U)

Ward or location

Consultant

Requesting Clinician

Bleep no. _____

Sample date (ddmm)

Time (24 hr clock)

Clinical Information

Specimen type

- **Urgent** - arranged by phone
- **Frozen section**

Investigation Required

- Adult Histopathology
- Paediatric Histopathology
- Cytology
- Immunofluorescence

- Consent has been obtained for this sample to be used for teaching or research
- Inoculation risk

Copy to

Signature

UBHT - Hospital Bacteriology/Mycology Request Form

<< Use approved patient ID label here

Hospital

Hospital Number

Surname

Forename

Date of birth | Gender (M,F or U)

Ward or location

Consultant

Requesting Clinician | Bleep no. _____

Sample date (ddmm) | Time (24 hr clock)

Relevant Clinical details to include known inoculation risk etc. / antimicrobial therapy

- Recent foreign travel *(state dates + country)*
- Pyrexial
- Discharge
- Asymptomatic
- Symptomatic

Antimicrobial therapy - Use 1st 5 letters

Tests required

- MC&S
- TB
- MRSA screen
- Mycology
- OTHER *(specify)*

- **Faeces MC&S**
- C.difficile
- Parasites
- Occult blood

Urines

- MSU
- CSU
- EMU (TB only)
- OTHER *(specify)*

Blood culture

- Peripheral
- Line

Wound/skin/pus/fluid etc

- Swab
- Pus/Fluid/Aspirate
- Tissue
- CSF
- Other

Please specify specimen site/type:

Genital / STI

- HVS/CX combined
- HVS
- Endocervical
- Urethral
- Rectal
- OTHER*(specify)*

Respiratory

- Sputum
- BAL
- OTHER *(specify)*

HPA - Hospital "Virology" Request

<< Use approved patient ID label here

Hospital

Hospital Number

Surname

Forename

Date of birth | Gender (M,F or U)

Ward or location

Consultant

Requesting Clinician | Bleep no. _____

Sample date (ddmm) | Time (24 hr clock)

Clinical details/date of onset. Please note samples will not be processed if insufficient clinical details are provided. Include any relevant travel or vaccination history.

Specify virology tests (see over) and sample site below if not covered in boxes

Antenatal Bloods Booked at:

- Rubella
- AntenatalSyphilis
- Hepatitis B
- HIV

STI Serology

- LGV
- Chlamydia
- Herpes specific
- Syphilis

Faeces Samples

- Viral Gastroenteritis
- Helicobacter Ag
- C.difficile

- **Vesicle Fluid**
- **Swab /specify**
- **Legionella urine**

Viral Serology (clotted)

- Organ Donor
- Eye Donor
- Female Infertility Screen
- Male Infertility Screen
- Sperm Donor Virology
- Renal Transplant Screen
- Hepatitis Clinic Profile
- Needle-Stick Donor Test
- Hep B post vaccine test
- BBMR Profile
- BMT Profile

- CSF
- EDTA Blood/PCR tests
- NPA
- NAAT CHLAMYDIA

UHBristol - Antibiotic Assay Request Form

<< Use approved patient ID label here

Hospital

Hospital Number

Surname

Forename

Date of birth Gender (M,F or U)

Ward or location

Consultant

Requesting Clinician Bleep no. _____

Sample date (ddmm) Time (24 hr clock)

Inoculation Risk? Yes No

Patients weight _____

Is renal function impaired? Yes No

Underlying illness / Site of Infection :

Other Antibiotics:

NB. All assays must reach laboratory before 1600h to ensure same day processing. If Urgent please phone laboratory

Mark boxes so [X] **Complete Section A and B**

Antibiotic to be assayed *(please state below)* [A]

Antibiotic	Frequency	Dose given	Specimen
Gentamicin	od	_____	Pre-dose only
	bd, tds	_____	Pre-dose + 1hr Post dose
Vancomycin	od, bd	_____	Pre-dose only
Tobramycin	od	_____	Pre-dose only
	bd, tds	_____	Pre-dose + 1hr Post dose
Amikacin	od	_____	Pre-dose only
	bd, tds	_____	Pre-dose + 1hr Post dose
Teicoplanin	od	_____	Pre-dose only

Other *(please state)* _____

[B]

	dd	mm	24h clock h	24h clock m
Date antibiotic started				
Date /time last dose of antibiotic *(before this sample)*				
Date / time pre- dose specimen				
Date / time post - dose specimen				

REQUEST FOR BLOOD TRANSFUSION

University Hospitals Bristol NHS Foundation Trust

DO NOT USE COMPUTER LABELS ON SAMPLES

PLEASE READ NOTES ON BACK OF FORM

Reason for Transfusion:

Samples must not be used for teaching or research ☐ ( )

SPECIAL PRODUCT REQUIRED YES / NO

Give Reason:
(Please telephone laboratory to alert if new requirement)

Irradiated ☐ (✓) C.M.V. Neg ☐ (✓) Other ☐ (✓)

Group and hold only ☐ (✓)

When Required: Date: .....Time:.....

Red Cell Units .....

Other Products .....

History

Blood Group (if known) .....

Previously transfused YES / NO Approx. date.....

Irregular antibodies ..... Reactions .....

Recent Hb .....Inoculation Risk YES / NO

For Laboratory Use:

Confirm Group ..... Rh .....

Antibody Screen NEGATIVE / POSITIVE

Requesting Dr. (Print Name) .....Bleep No. .....

Sample Taken by (Print Name) .....Date: .....

Date: .....Time:.....

Hospital No: .....

Surname: .....

Forenames: .....

Home Address: .....

.....

Post Code .....

Sex: M / F

Date of Birth: .....

Hospital: ..... Consultant Code:.....

Ward: .....

Location Code:.....

NHS ☐ Private ☐ (✓)

				Laboratory Reference Number:
Antibody Screen	Gel	4 Cell		
Cell 1				
Cell 2				
Cell 3				
Cell 4				
DCT				