ROTUNDA HOSPITAL DEPARTMENT OF LABORATORY MEDICINE

RF-MICRO-0022 Additional Requesting Form Ed. 00

PLEASE COMPLETE THIS FORM FOR ANY ADDITIONAL TESTS REQUIRED

AND EMAIL IT TO serology@rotunda.ie

REQUESTING CLINICIAN DETAILS

Clinician Name _____

Registration Number _____

Contact Details _____

Mobile Number _____

Date Requested _____/_____/_____

PATIENT DETAILS

Hospital Number_____

First Name _____

Surname _____

Date of Birth ____ / ____ / _____

ORIGINAL SAMPLE DETAILS

Booking / Sample Number _____

Additional Sample Identifier (if applicable) _____

Date Sample Taken ____ / ____ / _____

Additional tests required

1._____

2._____

3._____

4. _____

Additional Comments / Clinical Information
