25		OLINICIAN									SOURCE							
25 Harley Street, London W1G 9QW  Monday to Friday 8:00AM to 8:00PM						Doctor									Additional copy of results to:			
Telephone: <b>0207 079 2100</b>						Address												
Email:	κ																	
P		Tel Fax																
SURNAME										DOB					When completing this form			
FORENAME						TITLE							M/F				please provide at least three unique identifiers for your patient.	
Pleas					ECG	CG					Patient	Ref/ID	No.					
(Biochemistry)				PP1 []	Home	Home Visit			Ī	=								
(Biochemistry/HDL)				PP1L [	PATIE	ATIENT DETAILS											PROFILES AND TESTS  Please specify	
(Haem/Bio)				PP2	LMP:													
(Haem/Bio/HDL) PP2L PP2L					Last	Last smear:												
(Haematology) PP3					Pouti	MONTH YEAR												
(Haem/Bio (short)) PP4					Routine screen  Colposcopy													
(Haem/Bio/HDL) PP4L				Previ	Previous HPV -ve  +ve +ve													
(Postal Haem/Bio) PP5 PI					Previ	Previous abnormal history (please specify):												
(Postal Haem/Bio/HDL) PP5L PP5L																		
Well Person Screen (DL2/T4/TSH/Ferritin)				PP6														
Well Person Screen (DL2L/T4/TSH/Ferritin)			F	PP6L	PAPT	ESTS (PLEASE SPECIFY) PAPT Inin Prep Cervical Cytology  IPV HR-HPV DNA ollective reporting of HPV subtypes  IP20 20 HPV DNA subtypes Iow risk, 15 high risk)			Г	$\neg$								
Well Man Screen (DL6/PSA/Ferritin)			F	PP7						=								
Well Man Screen (DL6L/PSA/Ferritin)			F	PP7L	Collecti				L	_								
Well Woman Screen (DL6/VITD/Ferritin)			F	PP8					es									
Well Woman Screen (DL6/HDL/VITD/Ferritin)			tin) F	PP8L	HP20 w	PVT Typed DNA/mRNA P20 with reflex mRNA for E6/E7												
Senior Male Profile 60+			F	РР9М	1	ncoprotein expression			Г	<b>-</b> ,								
Senior Female Profile 60+			F	PP9F	Thin Pre	hin Prep Chlamydia			L	_								
Cardiovascular Risk Evaluation Profile				PP10	TGO! Thin Pre	GON hin Prep Gonorrhoea				<b>⊿</b>								
Cardiovascular Risk Plus Profile			F	PP11	TCG Thin Pre	rep CT/GC					Clinical Details							
Sexual Health 7 STI screen by PCR				PP12	7 STI S	(PP12) creen by PC	R		Fasting (tick Ethnic Origin Drug Therap			Origin (det	tails, if relevan	t)				
Fe	e to be paid	by Patie	ent/Oth	er. <b>PLEA</b>	SE PRO	OVIDE ADDRESS DETAILS											ee to be paid by octor/Clinic as above	
Insurance Co.						Membership No.										Signatu	re	
Patient address																_	mple taken	
Butterda Control of																Time sample taken		
Postcode Contact telepho																	1	
	ce Use Only	OI	HERS	INITIALS	For Laboratory Use Or			nly: MSU		OTHERS INITIALS		For Pati	ent Serv	rice's Use				
		MSU											R	Ph	Ph	INITIALS	PHOENIX HOSPITAL GROUP	