

PATIENT RECEPTION AT:
 25 Harley Street, London W1G 9QW
 Monday to Friday **8:00AM to 8:00PM**
 Telephone: **0207 079 2100**
 Email: **info@phoenixpathology.co.uk**



CLINICIAN

Doctor
Address

Tel

Fax

SOURCE

Additional copy of results to:

When completing this form please provide at least three unique identifiers for your patient.

SURNAME				DOB	
FORENAME	TITLE		M/F		

Please Tick

(Biochemistry)	PP1	<input type="checkbox"/>
(Biochemistry/HDL)	PP1L	<input type="checkbox"/>
(Haem/Bio)	PP2	<input type="checkbox"/>
(Haem/Bio/HDL)	PP2L	<input type="checkbox"/>
(Haematology)	PP3	<input type="checkbox"/>
(Haem/Bio (short))	PP4	<input type="checkbox"/>
(Haem/Bio/HDL)	PP4L	<input type="checkbox"/>
(Postal Haem/Bio)	PP5	<input type="checkbox"/>
(Postal Haem/Bio/HDL)	PP5L	<input type="checkbox"/>
Well Person Screen (DL2/T4/TSH/Ferritin)	PP6	<input type="checkbox"/>
Well Person Screen (DL2L/T4/TSH/Ferritin)	PP6L	<input type="checkbox"/>
Well Man Screen (DL6/PSA/Ferritin)	PP7	<input type="checkbox"/>
Well Man Screen (DL6L/PSA/Ferritin)	PP7L	<input type="checkbox"/>
Well Woman Screen (DL6/VITD/Ferritin)	PP8	<input type="checkbox"/>
Well Woman Screen (DL6/HDL/VITD/Ferritin)	PP8L	<input type="checkbox"/>
Senior Male Profile 60+	PP9M	<input type="checkbox"/>
Senior Female Profile 60+	PP9F	<input type="checkbox"/>
Cardiovascular Risk Evaluation Profile	PP10	<input type="checkbox"/>
Cardiovascular Risk Plus Profile	PP11	<input type="checkbox"/>
Sexual Health 7 STI screen by PCR	PP12	<input type="checkbox"/>

ECG

Home Visit

PATIENT DETAILS

LMP: _____

Last smear: _____
MONTH YEAR

Routine screen

Colposcopy

Previous HPV -ve +ve

Previous abnormal history (please specify): _____

TESTS (PLEASE SPECIFY)

PAPT
Thin Prep Cervical Cytology

HPV HR-HPV DNA
Collective reporting of HPV subtypes

HP20 20 HPV DNA subtypes
(5 low risk, 15 high risk)

HPVT Typed DNA/mRNA
HP20 with reflex mRNA for E6/E7 oncoprotein expression

TPCR
Thin Prep Chlamydia

TGON
Thin Prep Gonorrhoea

TCG
Thin Prep CT/GC

7 STI (PP12)
7 STI Screen by PCR

Patient Ref/ID No. _____

PROFILES AND TESTS
Please specify

Clinical Details

Fasting (tick if yes)

Ethnic Origin (details, if relevant)

Drug Therapy (Please specify)

Fee to be paid by Patient/Other. **PLEASE PROVIDE ADDRESS DETAILS**

Insurance Co. _____ Membership No. _____

Patient address _____

Postcode _____ Contact telephone number _____

Fee to be paid by Doctor/Clinic as above

Signature _____

Date sample taken _____

Time sample taken _____

For Practice Use Only:						For Laboratory Use Only:						For Patient Service's Use Only:			
EDTA	SST	GREY	MSU	OTHERS	INITIALS	EDTA	SST	GREY	MSU	OTHERS	INITIALS	TIME IN	TIME IN	TIME OUT	TAKEN BY
												R	Ph	Ph	INITIALS