

# Pathology Clinical Request Form

## Tanzanite One and Beryl



Urgent                                  Copies to Doctors: \_\_\_\_\_                                  Contact Person: \_\_\_\_\_  
 Routine                                    Test Laboratory: \_\_\_\_\_

### Referring Family Practitioner Details

Doctor's Name: \_\_\_\_\_ Practice no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Tel no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Fax no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Email: \_\_\_\_\_  
 Signature \_\_\_\_\_

**Patient details (Patient to complete)**

Male     Female    Date of birth [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Surname: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Medical Scheme: \_\_\_\_\_  
 Medical Scheme Option: \_\_\_\_\_  
 Member no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Dependent code [ ] [ ]

**Person responsible for payment of account**

ID Number: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Surname: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Tel Number: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Postal Address: \_\_\_\_\_  
 \_\_\_\_\_

I certify that the above information is correct and give specific consent for selected test(s) to be done. I authorise the disclosure of these results to my doctor, medical aid administrators and/or insurance company. I fully understand the implication of the test(s) and have received adequate pre-test counselling.

Patient Signature \_\_\_\_\_ ICD10 Codes: \_\_\_\_\_

Clinical Information: \_\_\_\_\_

Please note that the prices listed below are reference prices only. GEMS has specific arrangements in place with various laboratories.

Chemistry				Endocrinology		Inflammation/Immunology	
Renal / electrolytes / bone	Request	Endocrine - thyroid	Request	Auto-immune	Request		
Creatinine		TSH		CRP			
Calcium (serum - no cuff)		Free T4		ESR			
Magnesium		<b>Endocrine - reproductive</b>		Uric acid			
Phosphate (serum)		b-HCG screen		Rheumatoid factor			
Sodium		Prolactin (rest 15 minutes)		ANF			
Potassium		<b>Diabetes</b>		Agglutination test per antigen			
Urea		Glucose fasting		<b>Infectious diseases</b>			
Lactate		Glucose random		VDRL (Qualitative)			
<b>Liver / pancreas</b>		HBA1C		VDRL (Quantitative)			
Albumin		Creatinine		Rubella immunity (IgG only)			
Total protein		Microalbuminuria (quantitative)		<b>Hepatitis tests: specify</b>			
ALP		<b>Ante-natal screen</b>		Acute hepatitis A (IgM)			
ALT		Haemoglobin estimation		Chronic hepatitis A (IgG)			
AST		Platelet count		Acute hepatitis B (Bs AG)			
Bilirubin (total, conjugated) - fee		Blood group: A B and O antigen		Hepatitis B (carrier/immunity : BsAB)			
GGT		Coombs test		<b>HIV tests</b>			
Lactate dehydrogenase		Grouping: Rh antigen		HIV 1+2 Ab + P24 Ag			
Lactate dehydrogenase		HEP B s Ag		HIV Ab - Rapid Test			
<b>Cardiac / muscle</b>		HIV 1+2 Ab + P24 Ag		CD4 count			
Troponin		VDRL		<b>HIV PCR Testing</b>			
CK-MB mass		Rubella igg, IgM - fee		HIV PCR viral load			
<b>Lipids / cad risk</b>		<b>Tumour markers</b>		<b>Microbiology</b>			
Cholesterol		PSA		Micro specimen type and site			
HDL and LDL		<b>Haematology</b>		MCS			
Triglycerides (fasting)		Grouping: A B and O antigens		AFB fluorochrome auramine (ZN) only			
Creatinine kinase (ck)		Grouping: Rh antigen		Parasites			
<b>Histology</b>		Full blood count		Bilharzia microscopy			
Histology per sample		Platelet count		<b>TB tests</b>			
Clinical data (please supply):		Haemoglobin estimation		TB culture			
Specimen type:		Reticulocyte count		TB sensitivity			
		Iron		Adenosine deaminase (Peritoneal)			
		Transferrin		Adenosine deaminase (Pleural)			
<b>Cytology</b>		Folate (serum)		<b>The following TB related tests require an authorisation</b>			
Cervical/vaginal smear		Vit B12		TB PCR Testing			
Specimen type:		Coombs test		For advanced pathology tests not included on this form, please contact 0860 436 777 and request an authorisation number.			
		Parasites in blood smear		Other tests requested:			
Collected By:		<b>Coagulation</b>		<b>Pre-authorisation number:</b>			
Collection Date:		INR/PI					
Collection Time:		<b>Miscellaneous</b>					
		Faecal occult blood test (FOB)					