PathCare

CENTRAL LABORATORY: Plot 1397b Tiamiyu Savage St. V/I.,Lagos. Enq.: (01) 4616311, 4546160, 461 0434-5 Fax: (01) 270 5995

IBADAN LABORATORY: 11 Ladoke Akintola Street, Off Are Avenue, New Bodija, Ibadan. Tel: 0703 852 3828

AJAH DEPOT: Suite C, Office 22, Ajah Shopping Mall, Ajah, Eti-Osa LGA Tel: 0810 813 6924

FESTAC DEPOT: Ground Floor, Ona World Plaza, (Beside UBA PLC) 23 Road Festac Town, Lagos. Tel: 0806 304 9410

IKEJA DEPOT: 66 Oduduwa Way, G.R.A. Ikeja. Lagos Tel: 0810 460 7647

• Abuja • Benin • Enugu • Gwagwalada • Ilorin • Kaduna • Port Harcourt • Warri

Referring Doctor	File Number	RESULT DELIVERY: KEEP FOR PATIENT	SEND TO HOSPITAL	E-MAIL	URGENT
Hospital & Ward					Contact Person:
Title	Patient Surname	Patient First Name			Please tick no. supplied (✓) Tel ☐ Cell ☐

Address / Postal Address

Tel. (h)	Tel. (w)	Cell	E-mail
Date of Birth D M Y	GENDER (✓) M F	Company / Health Insurance	Company I.D No. Health Insurance No.

I certify that the above information is correct and give specific consent for selected test(s) to be done. I authorise you to disclose these results to my medical administrators and/or HMOs. I undertake to pay all outstanding monies not covered by the HMO. I fully understand the implication of the test(s) I requested.

SIGNATURE

BILL COMPANY / HEALTH INSURANCE ☐

BILL HOSPITAL ☐ **BILL PATIENT** ☐

Relevant Clinical Data and Present Medication: LMP D M Y FASTING (✓) ☐ YES ☐ NO

Other Tests:

CHEMISTRY

G	1001 ☐	ELECTROLYTES / UREA \ CREATINNIE
G	1263 ☐	ELECTROLYTES
G	1262 ☐	UREA
G	1261 ☐	CREATININE
GU◇	1005 ☐	CREATININE CLEARANCE
F	1044 ☐	GLUCOSE (fast)
F	1045 ☐	GLUCOSE (random)
☎	1046 ☐	GLUCOSE TOLERANCE (2hr)
P	1048 ☐	HbA1c (GLYCATED Hb)
G	1038 ☐	LIPOGRAM (Fasting)
G	1016 ☐	LIVER FUNCTIONS
G	1007 ☐	URIC ACID (serum)
U	1006 ☐	PROTEIN (24hr Urine)
K	1020 ☐	BILIRUBIN (Neonatal)

ENDOCRINOLOGY

G	1236 ☐	DOWN'S SCREEN (see reverse side)
G	1064 ☐	MENOPAUSAL SCREEN
GG	1065 ☐	HIRSUTISM SCREEN
G	4860 ☐	MENSTRUAL IRREGULARITY SCREEN
G	3203 ☐	OVULATORY PROFILE (Day 21)
GG	1067 ☐	INFERTILITY (Female) (rest 15 minutes)
G	1068 ☐	INFERTILTY (Males) (rest 15 minutes)
G	1951 ☐	FREE ANDROGEN INDEX (SHBG testosterone)
G	4859 ☐	GALACTORHOEA SCREEN (rest 15 minutes)
GG	1361 ☐	PITUITARY SCREEN (rest 15 minutes)
P/GG/U◈	2973 ☐	OSTEOPOROSIS SCREEN
☎	1069 ☐	SEMEN ANALYSIS
G	1062 ☐	THYROID FUNCTIONS (TSH / T4)
G	1063 ☐	THYROID ANTIBODIES

PRE-IVF TREATMENT SCREENING

G	EIVF ☐	Pre IVF Full Screen
G	1074 ☐	FSH
G	1075 ☐	LH
G	1073 ☐	SERUM PROLACTIN (REST FOR 15 MINUTES)
G	1079 ☐	DHEA-S
G	1203 ☐	HIV I & II ANTIBODIES
G	1213 ☐	HEPATITIS B SAg
G	1202 ☐	HEPATITIS C
G	1179 ☐	RUBELLA IMMUNITY (IGG ONLY)
G	1058 ☐	TSH
G	1077 ☐	PROGESTERONE
G	1076 ☐	OESTRADIOL
G	1080 ☐	FREE TESTOSTERONE

SEROLOGY

GGP	1396 ☐	ARTHRITIS SCREEN
GP	1165 ☐	AUTO-IMMUNE SCREEN
G	1171 ☐	CARDIOLIPIN ANTIBODIES
G	ZSMUMG ☐	MUMPS ELISA IGG
G	ZSMUMM ☐	MUMPS ELISA IGM
G	SCHL ☐	CHLAMYDIA IGG
U	1184 ☐	CHLAMYDIA PCR (Urine)
G	1186 ☐	HERPES SIMPLEX I /II
G	1203 ☐	HIV 1 & 2 ANTIBODIES
G	2342 ☐	RPR / VDRL
G	1179 ☐	RUBELLA IMMUNITY (IgG ONLY)
G	2345 ☐	RUBELLA IgM
	2480 ☐	TORCH SCREEN

TUMOR MARKERS

G	1094 ☐	AFP
G	1092 ☐	CA 125 (Ovary)
G	1093 ☐	CA 15.3 (Breast)
G	1090 ☐	CEA (G.I.T., Lung, Breast)

ENDOCRINOLOGY

G	1071 ☐	β-HCG (Quantitative)
G	EAMH ☐	ANTI-MULLERIAN HORMONE
G	1076 ☐	OESTRADIOL
G	1077 ☐	PROGESTERONE (Ovulation day 21)
G	1080 ☐	TESTOSTERONE (TOTAL)
G	ESHBG ☐	SEX HORMONE BIND GLOBULIN (SHBG)
G	1073 ☐	PROLACTIN (rest for 15 minutes)
G	1079 ☐	DHEA-S
G	1058 ☐	TSH
G	1060 ☐	FREE T4
G	1061 ☐	FREE T3

MICROBIOLOGY

	MPUS ☐	URETHRAL / VAGINAL SWAB
U	MUR ☐	URINE MC&S

CYTOGENETICS

DCYTOBLOOD	☐	KARYOTYPING (BLOOD)
DCYTOAMNIO	☐	KARYOTYPING (FOETUS)

HAEMATOLOGY

GPR	1107 ☐	ANTENATAL SCREEN
GGPR	1108 ☐	ANTENATAL SCREEN & HIV
P	1110 ☐	FBC
P	1114 ☐	ESR
P	1122 ☐	Hb ELECTROPHORESIS
R/G	1123 ☐	BLOOD GROUP + ANTIBODY SCREEN
G	1117 ☐	FERRITIN
PG	1118 ☐	FOLATE
G	1119 ☐	VITAMIN B 12

CYTOLOGY

RELEVANT CLINICAL DATA AND PRESENT MEDICATION (Please supply)

LMP

☐ PREGNANT /40W

☐ POSTPARTUM /52W

☐ LACTATING

☐ POSTMENOPAUSAL

☐ LASER-/CRYOTHERAPHY

☐ RADIO-Rx / CHEMO-Rx

☐ IUD

☐ HORMONES (SUPPLY)

_____

_____

SPECIMEN ORIGIN

ECTOCERVIX ☐ ENDOMETRIUM

ENDOCERVIX ☐ VAGINAL VAULT

POSTERIOIR FORNIX ☐ VULVA

LAT FORNIX FOR HORMONAL ASSESMENT

PREVIOUS REFERENCE No.

(p.t.o.)

530 ☐ Home

Collected by	Date
Location code	Time

FOR LABORATORY USE

Received by		Logged by
Date	Time	Checked by

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ 8 ☐ 9 ☐ 10 ☐ 20 ☐ 30 ☐ 40

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Referring Doctor	File Number	**RESULT DELIVERY**		**URGENT** ☐
Hospital & Ward		**KEEP FOR PATIENT** ☐	**SEND TO HOSPITAL** ☐	**E-MAIL** ☐
Title	Patient Surname	Patient First Name		Contact Person:
				Please tick no. supplied (✓) Tel ☐ Cell ☐
Address / Postal Address				
Tel. (h)	Tel. (w)	Cell		E-mail
Date of Birth D M Y	GENDER (✓) M ☐ F ☐	Company / Health Insurance		Company I.D No. Health Insurance No.

I certify that the above information is correct and give specific consent for selected test(s) to be done. I authorise you to disclose these results to my medical administrators and/or HMOs. I undertake to pay all outstanding monies not covered by the HMO. I fully understand the implication of the test(s) I requested.

SIGNATURE

BILL COMPANY / HEALTH INSURANCE ☐

BILL HOSPITAL ☐ **BILL PATIENT** ☐

Relevant Clinical Data and Present Medication: LMP D ☐☐ M ☐☐ Y ☐☐☐☐ FASTING (✓) ☐ YES ☐ NO

Other Tests:

DOWN'S SYNDROME and OPEN NEURAL TUBE SCREENING

General patient information. Must be completed in all cases:

PATIENT'S DATE OF BIRTH: d d m m y y y y

ETHNIC ORIGIN (✓) white coloured black asian

WEIGHT (at time blood taken): . kg

NUMBER OF FOETUSSES:

DATE BLOOD SPECIMEN TAKEN: d d m m y y y y

Please indicate (✓) which screen is required and complete that section only:

1236 2nd TRIMESTER

Take blood from 15w to 20w 6d

1094 AFP only (NTD)

Take blood/fluid from 15w to 20w 6d

Please complete:

IS THE PATIENT A TYPE 1 DIABETIC (IDDM)? (✓) No Yes

GESTATIONAL AGE according to sonar: weeks days

ON d d m m y y y y

(Date when sonar was taken)

LMP (if sonar not done): d d m m y y y y

1237 1st TRIMESTER

Take blood from 11w to 13w 6d

Keep blood specimen cool, centrifuge within 6 hours. Send serum on ice.

Please complete:

PREVIOUS CHROMOSOMAL ANOMALY (✓): No T21 T18 T13

DOES THE PATIENT SMOKE ? (✓) No Yes

DATE ON WHICH SONAR WAS DONE: d d m m y y y y

CROWN-RUMP LENGTH on above date: . mm

NUCHAL TRANSLUCENCY (NT) . mm

SONAR PERFORMED BY:

The reliability of risk determination depends on the accuracy of the above data.
Please write clearly to prevent transcription errors.

530		Home	**FOR LABORATORY USE**	
Collected by	Date	Received by	Logged by	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Location code	Time	Date / Time	Checked by	☐8 ☐9 ☐10 ☐20 ☐30 ☐40