NHS GRAMPIAN CLINICAL LABORATORIES

Urgent/High Risk Samples
Please discuss with Department before Dispatch

Lab No

Patient Details (use label if available!

DOB/CHI No:

Surname:

Forename(s):

Spec Comment:
(Add Name of Care Home)

GP Practice Name:

Consultant: COVID

Copy To:

Name:

Signature:

Contact No: 58520

Date Printed:

INPATIENT ____

OUTPATIENT _X__

Sex: | **DOB:** | **Age:**

Specimen Type **COVID combined swab** **Specimen Date:** **Time.**

..........Clinical Details {NB Provide duration of illness/current antibiotic and if immunocompromised)

COVID symptomatic resident in care home
Onset of symptoms:
Symptoms:

Testing of Asymptomatic patients is not indicated

DEPARTMENT	PLEASE TICK APPROPRIATE BOX AND COMPLETE SEPARATE FORM FOR EACH DEPARTMENT
	Test(s) /Investigations Required (Consent Obtained Tick box)
BIOCHEMISTRY	
GENETICS	
HAEMATOLOGY	
IMMUNOLOGY	
PATHOLOGY	Please consider carefully clinical appropriateness of all test requests

MICROBIOLOGY (tick below)	VIROLOGY (tick below)	ANTENATAL TESTING (tick below)
Culture & Sensitivity	COVID 19.	Hepatitis B
Parasites (NB Cryptosporidia done routinely)		Rubella
Helicobacter Serology		Syphilis
Other (specify)	X	HIV
		All of the above

Date & Time of Receipt

Form ZOW710

Deliver To: —

VIROLOGY