MICROBIOLOGY REQUEST FORM

Derriford Hospital, Derriford Road, Plymouth PL6 8DH – Tel: 01752 792387 Fax: 01752 517725

CPA Accredited

Hospital No:

NHS No:

Surname

Forename

D.O.B. (dd/mm/yyyy)

If you have an address label please place it inside this box

Sex Male Female

NHS Private Sample NOT to be used for education?

GP / Consultant

Surgery / Ward

Requester signature/ Bleep no

Sample date (dd/mm/yy)

Time as 24 hr format (hh:mm)

Clinical Details: Please include antibiotic treatment, foreign travel, symptoms, duration etc

If test is private:
Please supply name / address / tel no for billing

Specimen type and site:

Investigations required:

FOR LABORATORY USE ONLY

L S F

CUL
CRY
ROT

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