

Patient Last Name		Given Name(s)	Sex	Date of Birth	Your Ref
Patient Address			Post Code	Tel (Home)	Tel (Bus)
Tests Requested					
Requesting Client			Extra Copy To		
Client Data Entry Code			Billing Code		
Collector Instructions					
Transport Instructions					
Laboratory Instructions					

I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of the patient by direct inquiry and/or by inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s).

SIGNED:

X

DATE:

TIME:

Clinical Laboratories Pty Ltd A.B.N. 62 006 823 089

Person collecting specimen(s)

GEL	EDTA	SOD CIT	FL OX	PLAIN	HEP	ESR
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24H U	MSU	SWAB	PAP	HIST	SLIDE	FAECE	SPUT
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FUNG	SEMEN	CSF	ECGTRACE
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HOLTRACE	OTHER	GEL
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CL-REQ-0001.3
(02/16)