

# REQUEST FOR DIAGNOSTIC SERVICES

Please refer to specimen collection and transportation requirements on the NRL website

REFERRED INDIVIDUAL'S DETAILS (Minimum 3 identifiers required)				
<b>Surname / Name Code:</b>		<b>Given Names:</b>		<b>UR Number:</b>
<b>Date of Birth:</b> (dd/mm/yyyy)	<b>Date and Time of Death:</b> (if applicable)	<b>Gender:</b> M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/>		<b>Pregnant?</b> No <input type="checkbox"/> Yes <input type="checkbox"/>
<b>Is the individual of Aboriginal and/or Torres Strait Islander origin? Please tick one box below:</b>				
No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Unknown <input type="checkbox"/>				
SENDER'S DETAILS				
<b>Requested by:</b>			<b>Institution Name &amp; Address for Reports:</b>	
<b>Telephone Number:</b>				
<b>Email Address:</b>				
<b>Request Date:</b> (dd/mm/yyyy)			<b>Copy to:</b>	
SAMPLE DETAILS				
<b>Sender Reference:</b>		<b>Sample Type:</b> (Tick appropriate box)		<b>Collection Date:</b>
<b>Circulating Blood:</b> <input type="checkbox"/>		EDTA <input type="checkbox"/> Plasma <input type="checkbox"/>		<b>Collection Time:</b>
<b>Non-Circulating Blood:</b> <input type="checkbox"/>		PPT <input type="checkbox"/> DBS <input type="checkbox"/>		
<b>Collected within 24 hours of death:</b> (If applicable) <input type="checkbox"/>		SST <input type="checkbox"/> Other <input type="checkbox"/>		<b>Freeze Date:</b> <b>Freeze Temperature:</b>
		Serum <input type="checkbox"/> -----		
<b>Clinical Notes / Sender's Results:</b>				
TESTS REQUESTED				
<b>Signature:</b>			<b>Date:</b>	

**Specimen Enquiries: +61 3 9418 1111**

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