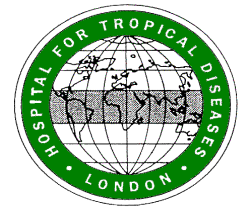


**Department of Clinical Parasitology
Hospital for Tropical Diseases**

Consultant Parasitologist: Prof. P. L. Chiodini
Scientific Lead: Dr. S. Polley



PARASITOLOGY REQUEST FORM

TBC

SENDER'S NAME/ADDRESS: Department of Laboratory Medicine,
National University Hospital
5 Lower Kent Ridge Road,
Main Building, Level 3,
Singapore 119074
Tel: (65)6772 4346,
Fax: (65)67792901

HSL Source Code: SINGLAB (UCLH Micro Winpath)

PATIENT DETAILS:

NHS No _____

Patient Hospital No: _____

PRIVATE **NHS**

Patient Surname/Family name: _____

Sex: _____

Patient Forename: _____

Date of birth/Age: _____

LABORATORY DETAILS:

Laboratory No: _____

Date & Time sample collected: _____

Serum CSF Other (please state specimen type): _____

Clinical details/diagnosis: _____

Date Onset: _____

Travel history: _____

PARASITOLOGY TESTS REQUIRED:

High Risk Sample? Yes No



**HEALTH SERVICES
LABORATORIES**

SEND SAMPLES AND REQUEST FORMS TO:

CONSULTANT PARASITOLOGIST
DEPARTMENT OF CLINICAL PARASITOLOGY,
HOSPITAL FOR TROPICAL DISEASES
THIRD FLOOR MORTIMER MARKET CENTRE
LONDON WC1E 6JB

DX Number: DX 6640701
Exchange: TOTTENHAM CT RD 91
Tel No: 020 7307 9400
MORTIMER MARKET
Fax No: 0207 383 0041

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