SUPRAREGIONAL ASSAY SERVICE

Surname	**Forename(s)**	Age/ DoB	Hospital:
			Hosp. No.
Consultant		M F	NHS No.

Your Accession No.	**Assay(s) Requested**
SAMPLE: Serum/ Plasma Date: Time: h Urine: Random/ 24h Vol: L	Diagnosis, Initial Investigations, Details of Therapy
Chemical Pathologist's Name & Address **Print Clearly**	
Chemical Pathologist's Signature **Tel. No. Ext.**	**Expected Value:** **High** **Medium** **Low**

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