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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