آغا خان یونیورسٹی ہسپتال

The Aga Khan University Hospital

REQUEST FORM FOR REFERRAL LABORATORY

Form #: LAB-QM-010cF1	**Issuance Date:** 01/01/2016	**Revision Date:** 01/01/2018	**Revision #:** 01
Section/Region:	**Area/Bench:**	**Year/ Month:**	**Page** 1 of 1

PATIENT DETAIL:

Patient Name: ______________________________ Gender: [ ] Male [ ] Female

Date of Birth: _________________ Home Address____

Contact Number: ___________________ Medical Record No.________________________________

Visit Type: [ ] In patient [ ] Outpatient Patient testing condition (if applicable) ________

REFERRING CLINICIAN DETAIL:

Referring Physician Name: ______________________ Designation ____________________________

Department: ____________________Contact No.___________________________ Pager No._______

Email: _________________________ Hospital/Institute: _____________________________________

Requested Test Description ______________________ Method detail __________________________

Specimen type:_______________________

Special condition for specimen collection (*if any*)____

Referral Laboratory complete information (*if available*) _____________________________________

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Reason for referral:

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Physician Signature: _______________________________________ Date: _________________________

Informed Consent: I understand and agree that the prescribed test from my Physician will be send to Referral Laboratory for testing.

Patient Name & Signature: ____________________________________ Date:_____________________

Note: Complete a separate requisition for each patient.