

REQUISITION FORM FOR PARASITOLOGICAL DIAGNOSIS

Specimens will only be processed when accompanied by this **completed** form

LAST NAME: _____ FIRSTNAME: _____ TITLE: _____

DATE OF BIRTH: _____ MALE/FEMALE: _____ HEIGHT: _____ WEIGHT: _____

ADDRESS: _____

CITY: _____ COUNTY: _____ POSTCODE: _____

HOME PHONE: _____ MOBILE PHONE: _____ EMAIL: _____

SPECIMEN COLLECTION DATES/COLLECTION SITE

FIRST STOOL SAMPLE: _____ SWAB: _____ FROM: _____

SECOND STOOL SAMPLE: _____ ID: _____ FROM: _____

BLOOD: _____ OTHER: _____ FROM: _____

HISTORY & EXPOSURE

FOREIGN TRAVEL (countries & dates within last 5years) _____

SYMPTOMS: _____

PAST INFECTION & TREATMENTS (most recent first) _____

OTHER HOUSEHOLD MEMBERS INFECTED: _____

Please submit results to Emma Lane via email to enquiries@parasitetesting.co.uk

For Parasite Testing Europe Limited use only

REFERRING PRACTITIONER: _____

DATE RECEIVED: _____ DATE SENT TO LAB: _____