



The Medical Specialists
Cardiac Screen Ltd

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BLOOD TEST REQUEST FORM

PATIENT DETAILS:

NAME:

PATIENT ADDRESS:

DATE OF BIRTH:

SEX: MALE / FEMALE

DATE OF REQUEST:

REFERRING DOCTOR:

CLINICAL DETAILS:

INVESTIGATION REQUIRED

Please select a box for the Blood Test required.

COMPREHENSIVE METABOLIC PROFILE

TROPONIN I (cTnI)

ELECTROLYTE PANEL PROFILE

CREATINE-KINASE MB (CK-MB)

LIPID PANEL PLUS PROFILE

B-TYPE NATRIURETIC PEPTIDE (BNP)

GENERAL CHEMISTRY PROFILE

INR

COMPLETE BLOOD COUNT PROFILE

PSA SCREENING

GLYCOSYATED HB (HbA1c)

H PYLORI SCREENING

C.REACTIVE PROTEIN (CRP)

ALBUMIN: CREATININE RATIO (ACR)

URINE ANALYSIS

ANY OTHER TESTS:

SIGNATURE OF REFERRER:

FOR APPOINTMENTS:

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