



SUPRAREGIONAL ASSAY SERVICE

Surname		Forename(s)		Age/ DoB	Hospital:
Consultant				M F	Hosp. 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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