



**REQUEST FOR LABORATORY SERVICES**  
SINGAPORE GENERAL HOSPITAL, DEPARTMENT OF PATHOLOGY  
CLIENT & SPECIMEN MANAGEMENT, TEL: 63265353, FAX: 62228924

Patient's Name : \_\_\_\_\_  
 NRIC/FIN/PP/REG # : \_\_\_\_\_  
 D.O.B and Age : \_\_\_\_\_ SEX: M / F  
 Race : \_\_\_\_\_  
 Nationality : \_\_\_\_\_  
 Patient's Mobile Phone Number : \_\_\_\_\_  
 Patient's Next-of-Kin's Mobile Phone Number : \_\_\_\_\_  
 Date of Request : \_\_\_\_\_  
 Date/Time of Specimen Collection : \_\_\_\_\_ am/pm Fasting Specimen: Yes / No

Requesting Physician's Name, MCR# , Signature and Contact Number :

*This contact number should enable our laboratory to contact the requesting physician or an assigned staff member even after business hours in the event that the laboratory test result(s) is within the critical range.*

Clinic's Name, Address, Telephone Number and Fax Number :

Brief Clinical History :

**POLYCLINIC PATIENT**

Test(s) requested: (Please  in box provided)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Stool Occult Blood    | <input type="checkbox"/> HBsAg  | <input type="checkbox"/> ABO RH                               | <input type="checkbox"/> AFP, serum                                       |
| <input type="checkbox"/> Stool Ova & Parasites | <input type="checkbox"/> Anti-HBs   | <input type="checkbox"/> APTT/PT                              | <input type="checkbox"/> CEA, serum                                       |
| <input type="checkbox"/> Stool Culture         | <input type="checkbox"/> Anti-HAV IgG   | <input type="checkbox"/> PT/INR                               | <input type="checkbox"/> PSA, serum                                       |
| <input type="checkbox"/> Urine Culture         | <input type="checkbox"/> Rubella IgG Ab                                       | <input type="checkbox"/> Full Blood Count                     | <input type="checkbox"/> Glucose, capillary                               |
|  | <input type="checkbox"/> Dengue IgM Ab  | <input type="checkbox"/> Blood Film Report                    | <input type="checkbox"/> HBA1c, blood                                     |
|  | <input type="checkbox"/> Dengue NS1 Ag  | <input type="checkbox"/> Malarial Parasite, blood film        | <input type="checkbox"/> Uric Acid, serum                                 |
|  | <input type="checkbox"/> HIV Screen   | <input type="checkbox"/> Dipstick and Microscopic Exam, urine | <input type="checkbox"/> RBC Cholinesterase, blood                        |
|  | <input type="checkbox"/> Hepatitis B Screen (HBsAg, anti-HBs or Anti-HBc IgM) |   | <input type="checkbox"/> Bilirubin, paediatric, serum                     |
|  |   |   | <input type="checkbox"/> hCG (Qualitative), urine                         |
|  |   |   | <input type="checkbox"/> Lipid Panel (CHO/HDL/TG/LDLc), serum             |
|  |   |   | <input type="checkbox"/> Renal Panel (U/E/BICARB/GLU/CRE), serum          |
|  |   |   | <input type="checkbox"/> Liver Panel (TP/ALB/TBIL/ALP/ALT/AST/GGT), serum |
|  |   |   | <input type="checkbox"/> Thyroid Panel (FT4/TSH), serum                   |

Others: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Laboratory Copy

Reg. No.:198703907Z

**PATIENTS. AT THE HEART OF ALL WE DO.®**

<b>FOR LABORATORY USE ONLY</b>	
<input type="checkbox"/>	PAID – Receipt No: .....
<input type="checkbox"/>	Total amount paid ..... <i>(includes GST)</i>

**Conditions for Laboratory Test Services:**

- 1 Laboratory Test Requests must be signed by the requesting physician and state
  - a) the requesting physician's name and contact number; and
  - b) the clinic's name, address, and telephone number and fax number.
- 2 The requesting physician's contact number should enable our laboratory to contact the requesting physician or the assigned staff member even after business hours in the event that the laboratory test result is within the critical range.
- 3 The requesting physician or assigned staff member needs to be readily contactable to ensure that timely medical advice is provided to the patient. It shall not be the Laboratory's responsibility to liaise, on behalf of the requesting physician, with the patient for notification of and advice on the laboratory test results or clinical management.
- 4 We reserve the right to decline performing the tests in the absence of any information that we require as indicated in the "Request for Laboratory Services" form.
- 5 The requesting physician and the clinic shall hold harmless and indemnify Singapore General Hospital against any claims arising from or in connection with inaccessibility of the requesting doctor or any authorised staff to receive the test results or failure by any of them to provide timely notification of laboratory test result(s) and medical advice to the patient.