

Patient Surname	Given Name(s)	Sex	Date of Birth	Your Reference
Patient Address		Post Code	Tel (Home/Mobile)	Tel (Bus)
<input type="checkbox"/> FBC <input type="checkbox"/> E/LFTs <input type="checkbox"/> Fasting Glucose <input type="checkbox"/> CRP <input type="checkbox"/> PSA <input type="checkbox"/> Lipids HDL/LDL and ratios <input type="checkbox"/> Iron Studies <input type="checkbox"/> GH, DHEAs, IGF-1, SHBG, Testosterone, Free Testosterone, FSH, LH, Prolactin, Progesterone, Oestrogen, Serum Cortisol <input type="checkbox"/> DHT (Dihydrotestosterone) <input type="checkbox"/> TSH, FT3, FT4 <input type="checkbox"/> Vitamin D <input type="checkbox"/> HbA1c <input type="checkbox"/> Urinary Microalbumin:Creatinine Ratio <input checked="" type="checkbox"/> Collection Fee – Data Entry Use Code: [CHA]				
Requesting Client: [Y8978] The Functional Doctors 280 Flinders Street Townsville QLD 4810 1800 370 690		Additional Copies To:		
Client Data Entry Code: Y8978		Billing Code: BILL TO PATIENT – ACCOUNT CLASS: [NUT]		
Collection Centre/Transport Instructions:				
Laboratory Instructions:				
Data Entry Instructions: <ul style="list-style-type: none"> • Please ensure code [CHA] is entered for every episode • Bill to: Patient • Account Class: NUT 				

I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of the patient by direct inquiry and/or by inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s).

FULL NAME

SIGNATURE

DATE:

TIME:

Person collecting specimen(s)

GEL	EDTA	SOD CIT	PL OX	PLAIN	HEP	ESR
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24H U	MSU	SWAB	PAP	HIST	SLIDE	FAECE	SPUT
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FUNG	SEMEN	CSP	ESGTRACE
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HOLTRACE	OTHER	GEL
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