SPECIMEN FORM

Please ensure all questions are answered to ensure your sample can be processed or tested
Please Note: if this form is not filled in correctly the sample will NOT be dipped

Name……

DOB…….. Age……

Date of specimen…… GP……

Type of sample: (please circle as appropriate) Sputum / Stool / Urine

Please complete **ALL** questions below.

I am a diabetic this is early morning specimen	Yes / No
This is a pre cardiac clinic sample	Yes / No

If Yes no further information needed

For URINE samples only	
Do you think you have a Urine Infection	Yes / No
Pain on passing urine	Yes / No
Passing urine more frequently	Yes / No
Pain in lower abdomen	Yes / No
Back pain	Yes / No
Cloudy or smelly urine	Yes / No
Blood in urine	Yes / No
Recurrent Urine Infections (3 or more a year)	Yes / No
It is second sample following treatment for urine infection.	Yes / No
Is the sample for a Bence-Jones test?	Yes / No

All samples

Do you have a temperature?	Yes / No
Are you allergic to antibiotics?	Yes / No
If so, which one(s)	
Are you or could you be pregnant?	Yes / No
If yes, how many weeks pregnant are you?	
Are you menstruating?	Yes / No

Has the sample been requested by a GP, if so who? Dr…….	Yes / No

THANK YOU FOR COMPLETING THIS FORM – Please drop the sample by no later than 11.30am

For Surgery Use:						
Scan to:	Self		GPs		Urgent	