

Diagnos^tics **VL**

VIRAL LOAD
TEST REQUEST FORM

PATIENT DETAILS

Affix patient label here

Hospital/Clinic No.

Sample ID

Patient Initials

Date of birth

Sex M F Other

Delphic
sticker ONLY

SAMPLE DETAILS

HBV Sample collection date Sample collection time : 24-hour clock

HCV Sample collection date Sample collection time : 24-hour clock

TEST REQUIRED

Test(s) required (tick as appropriate)

HBV

HCV

CLINICAL CENTRE INFORMATION

Customer number

Address

Postcode

Tel

Fax

Email

Contact

REQUESTING PHYSICIAN

Name (BLOCK CAPITALS)

Signature

Date

COMMENTS

FOR DELPHIC USE ONLY

Date of receipt of sample

Delphic ID

Test(s) required HBV

HCV

Please return the completed form plus minimum **2.5ml plasma** specimen **per test** in plastic tubes to:

Delphic Diagnostics, 1030 Heeley Close, Kent Science Park, Sittingbourne, Kent ME9 8HL

Delphic, DX 6403700, Sittingbourne 91M

Tel: 020 7499 0777 Fax: 020 7499 0775 Email: customerservices@delphicdiagnostics.com