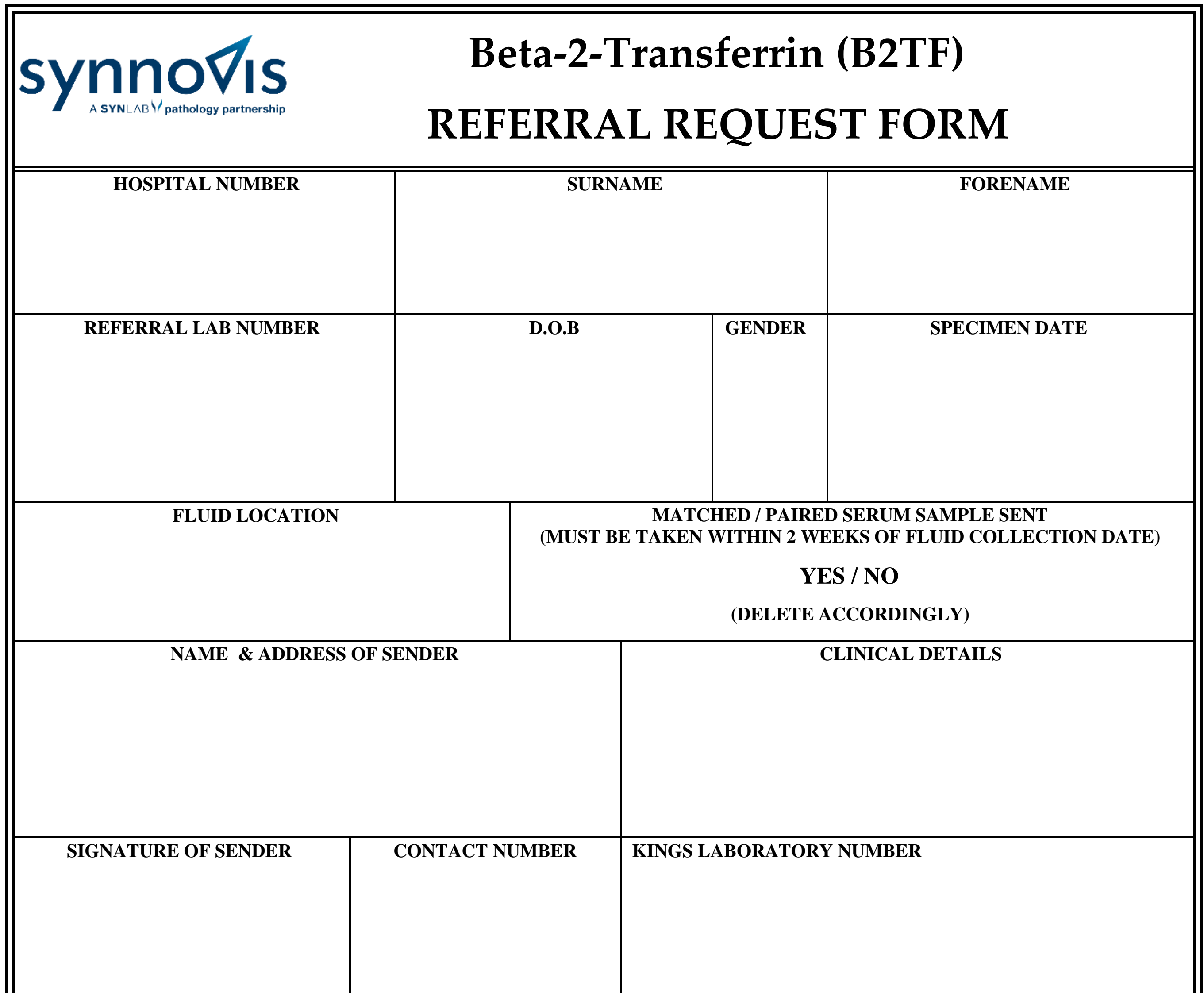

Beta-2-Transferrin (B2TF)

REFERRAL REQUEST FORM

HOSPITAL NUMBER	SURNAME		FORENAME
REFERRAL LAB NUMBER	D.O.B	GENDER	SPECIMEN DATE

FLUID LOCATION	MATCHED / PAIRED SERUM SAMPLE SENT (MUST BE TAKEN WITHIN 2 WEEKS OF FLUID COLLECTION DATE) YES / NO (DELETE ACCORDINGLY)

NAME & ADDRESS OF SENDER	CLINICAL DETAILS

SIGNATURE OF SENDER	CONTACT NUMBER	KINGS LABORATORY NUMBER

Please refer to website: www.synnovis.co.uk for more request forms