HEPATITIS TESTING SERVICE (HTS)

Liver Labs, Institute of Liver Studies
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PATIENT INFORMATION *		**SPECIMEN INFORMATION ***			**REFERRER INFORMATION ***	
SURNAME		Referrer Lab no.			Name	
FORENAME		Specimen Taken	Date (dd/mm/yyyy)		Hospital / Location	
DOB / AGE			Time (24hr format)		**REPORT / RESULTS DESTINATION / COMMUNICATION ***	
SEX		**ADDITIONAL SPECIMEN INFORMATION**			Tel. / FAX	
◯ **KING'S**	**HOSPITAL NO.**	Specimen Volume			Email	
◯ **EXTERNAL**		Specimen Type	◯ Serum ◯ EDTA Plasma ◯ Whole Blood (EDTA) ◯ Whole Blood (Serum)		Address (please include Postcode)	
◯ **NHS**	**NHS No.**					
◯ **Private**						
◯ **Others** Please Specify:					Billing Address & Email (if not same as above)	
Ward / Clinic						

REASON FOR REQUEST	**TEST(S) REQUIRED ***		
☐ ? Acute Viral Hepatitis	☐ HAVAb (IgG)	☐ HBV genotype	☐ Delta Ab (Total)
☐ ? Chronic Hepatitis / Carrier	☐ HAVAb (IgM)	☐ HBV drug resistance mutation	☐ Delta Ab (IgM)
☐ Chronic Hep B	☐ HBsAg	☐ HBcAb	☐ Delta RNA Quantitative
☐ Chronic Hep C	☐ HBsAg Quantitative	☐ HBcAb (IgM)	☐ HEV Ab (IgG)
☐ Parenteral drug user	☐ HBsAg Confirmatory	☐ HBsAb	☐ HEV Ab (IgM)
☐ Pre-antiviral treatment	☐ HBeAg	☐ HCV Ab	☐ HEV RNA (Qualitative)
☐ On antiviral treatment	☐ HBeAb	☐ HCV RNA Quantitative	☐ HEV RNA (Quantitative)
☐ End of antiviral treatment	☐ HBV DNA Quantitative	☐ HCV Genotype	
☐ Post-antiviral treatment	**Clinical Information / Previous results (e.g. treatment details, vaccination date etc.)**		
☐ Low CD4			
☐ Cirrhosis			
☐ HCC			
☐ Other (please specify →)			

For HTS laboratory use: Lab #	Received by: Date & Time:	

*** SPECIMEN WILL NOT BE ACCEPTED UNLESS CORRECTLY LABELLED, PACKED (PI 650 STANDARDS) & ACCOMPANIED BY A FULLY COMPLETED REQUEST FORM SENT TO OUR ADDRESS ABOVE**