



衛生署臨床病理化驗中心
DEPARTMENT OF HEALTH
CLINICAL PATHOLOGY LABORATORY CENTRE

Test Request Form

Surname		Report to Clinic/Institution	
Other Names			
HKID No.		()	
Sex	Age/DOB	Clinic Code :	
Clinical Diagnosis		Clinic/Institution Reference	
Dr.		Signature	
(Name in Block Letters)		Date Requested	
		Sample Collection Date : Time :	
Tube type	Profile test	Single test	
Gel tube	<input type="checkbox"/> Liver function test	<input type="checkbox"/> Sodium	<input type="checkbox"/> Total protein
<input type="checkbox"/> Fasting	<input type="checkbox"/> Renal Function test	<input type="checkbox"/> Potassium	<input type="checkbox"/> Albumin
<input type="checkbox"/> Spot	<input type="checkbox"/> Lipid profile	<input type="checkbox"/> Urea	<input type="checkbox"/> Total bilirubin
		<input type="checkbox"/> Creatinine	<input type="checkbox"/> Alk.phosphatase
		<input type="checkbox"/> ALT	<input type="checkbox"/> Calcium
		<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Phosphate
		<input type="checkbox"/> Triglycerides	<input type="checkbox"/> Urate
		<input type="checkbox"/> Gamma GT	<input type="checkbox"/> Fructosamine
Plain tube	<input type="checkbox"/> Thyroid function test	Clinical Information (Please <input checked="" type="checkbox"/> the most appropriate one)	
		<input type="checkbox"/> Suspected hyperthyroidism	Initial test: sTSH
		<input type="checkbox"/> Suspected hypothyroidism	Initial test: sTSH
		<input type="checkbox"/> Suspected 2° hypothyroidism	Initial test: FT4
		<input type="checkbox"/> 2° hypothyroidism on T4	Initial test: FT4
		<input type="checkbox"/> Hyperthyroidism on treatment	Initial test: FT4, sTSH
		<input type="checkbox"/> 1° hypothyroidism, thyroid nodule or carcinoma on thyroxine	Initial test: sTSH, FT4
<input type="checkbox"/> Other clinical situation (please specify) :		<input type="checkbox"/> sTSH	<input type="checkbox"/> FT4
		<input type="checkbox"/> FT3	
		<input type="checkbox"/> RF	<input type="checkbox"/> ANA
		<input type="checkbox"/> Anti-Tg/Tm	
EDTA tube	<input type="checkbox"/> CBC	<input type="checkbox"/> Retics	<input type="checkbox"/> RBC morphology
	<input type="checkbox"/> CBC & Diff	<input type="checkbox"/> ESR	<input type="checkbox"/> HbA1c
Citrate tube		<input type="checkbox"/> PT/INR	<input type="checkbox"/> APTT
		(Collection time must be provided)	
Fluoride tube		<input type="checkbox"/> Glucose	<input type="checkbox"/> OGTT
<input type="checkbox"/> Fasting	<input type="checkbox"/> Spot		
Urine		<input type="checkbox"/> Protein	<input type="checkbox"/> Creatinine
<input type="checkbox"/> 24 hrs.	Vol. Litres	<input type="checkbox"/> Catecholamines	<input type="checkbox"/> VMA
Other Tests Required :			