

Referring Doctor	Doctor's Code	Copies to Doctors	Medical Centre/Hospital & Ward	File No.
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PATIENT DETAILS	File No.	ACCOUNT TO (★ Compulsory - please complete)
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Patient ID. No.	Patient Surname	Patient First Name	Is this your first visit to NAMPath? (✓) YES NO	★ Guarantor ID No.	★ Surname & Initials
Date of Birth	Gender (✓) M F			★ Postal Address	
Tel. (h)	Cell			★ Tel. (h)	
Tel. (w)	E-mail			★ Tel. (w)	

I certify that the above information is correct and give specific consent for selected test(s) to be done. I authorise you to disclose these results to my medical aid administrators and/or insurance company I undertake to pay all outstanding monies not covered by medical aid. I fully understand the implication of the test and have received adequate pre-test counselling.

SIGNATURE:	SIGNATURE:	★ Medical Aid	★ Medical Aid No. or Receipt No.	
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Collected by	Date	Time	Location code	★ Employer Name	Tel.
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Relevant Clinical Data and Present Medication	Tel:.....	BARCODE STICKER
	Fax:.....	
	Email:.....	

Special Request	ROUTINE	URGENT	
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Site Priority	Location code	Date	Time	SPECIMEN INFORMATION AND COUNT															
Received by				URINE	HEPARIN	EDTA 4ml 6ml	CITRATE	GEL	ACD	CLOTTED	FLUORIDE	OTHER-please specify							

ANTENATAL SCREENING TEST			
<input type="checkbox"/> ANTENATAL SCREEN	<input type="checkbox"/> FULL BLOOD COUNT	<input type="checkbox"/> RPR, T pallidum IgG	<input type="checkbox"/> HEP B s Ag
<input type="checkbox"/> ANTENATAL SCREEN + HIV	<input type="checkbox"/> HAEMOGLOBIN	<input type="checkbox"/> RPR only	<input type="checkbox"/> HIV 1+2 Ab + P24 Ag
	<input type="checkbox"/> BLOOD GROUP	<input type="checkbox"/> Rubella IgG only	<input type="checkbox"/> GLUCOSE fasting
	<input type="checkbox"/> RBC ANTIBODY SCREEN		<input type="checkbox"/> GLUCOSE random

PRENATAL SCREENING TEST	
<input type="checkbox"/> 1st Trimester Biochemistry only (8 weeks - 13 weeks 6 days → Please complete)	
Gestational age as per sonar	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	week day date of sonar done
Sonographer: _____	FMF# _____
Copy of results must go to doctor _____	

ANTENATAL SCREEN	
ANTENATAL SCREEN	- FBC, RPR, (TPHA if RPR positive), Blood grouping (ABO and Rh), Antibody screen, Rubelle IgG, Hep B s Ag
ANTENATAL SCREEN + HIV	- FBC, RPR, (TPHA if RPR positive), Blood grouping (ABO and Rh), Antibody screen, Rubelle IgG, Hep B s Ag + HIV
1st TRIMESTER BIOCHEMISTRY	- free BHCG & PAPP-A

ENQUIRIES



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