



Clinic name

Address · Phone · Licence no.

Laboratory order

Tick what you need; write anything not listed on the free lines.

Patient name _____ File no. _____ Date of birth _____
Phone _____ Date _____ Doctor _____
Clinical notes _____ Provisional diagnosis _____

Haematology

- | | | | |
|------------------------------|-----------------------------------|--|--|
| ☐ CBC | ☐ ESR | ☐ Blood group | ☐ PT / INR |
| ☐ PTT | ☐ Ferritin | ☐ Iron and TIBC | ☐ Reticulocytes |

Chemistry

- | | | | |
|--|---------------------------------------|--|--|
| ☐ Fasting glucose | ☐ HbA1c | ☐ Lipid profile | ☐ Kidney function |
| ☐ Liver function | ☐ Electrolytes | ☐ Uric acid | ☐ Calcium |

Hormones

- | | | | |
|---------------------------------------|---------------------------------------|------------------------------------|-----------------------------------|
| ☐ TSH | ☐ Free T4 | ☐ Prolactin | ☐ FSH / LH |
| ☐ Testosterone | ☐ β -hCG | ☐ Cortisol | ☐ Insulin |

Vitamins and minerals

- | | | | |
|------------------------------------|--------------------------------------|---------------------------------|------------------------------------|
| ☐ Vitamin D | ☐ Vitamin B12 | ☐ Folate | ☐ Magnesium |
| ☐ Zinc | ☐ Phosphorus | | |

Infection and immunity

- | | | | |
|------------------------------------|--------------------------------------|--|--|
| ☐ CRP | ☐ HBsAg | ☐ HCV antibody | ☐ HIV |
| ☐ H. pylori | ☐ Throat swab | ☐ Blood culture | ☐ Rheumatoid factor |

Urine and stool

- | | | | |
|-------------------------------------|--|---|---|
| ☐ Urinalysis | ☐ Urine culture | ☐ Urine pregnancy test | ☐ Stool analysis |
|-------------------------------------|--|---|---|

Other

Fasting required ☐ Yes ☐ No

Sample collected at the clinic ☐ Yes ☐ No

Priority ☐ Routine ☐ Soon ☐ Urgent

Send results to ☐ Patient's WhatsApp ☐ Email ☐ The clinic

Doctor's name and signature

Stamp

Date and time



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Radiology order

The modality, the region, and the question you want answered.

Patient name _____ File no. _____ Date of birth _____
Phone _____ Date _____ Doctor _____

Examination

☐ X-ray ☐ Ultrasound ☐ CT
☐ MRI ☐ Mammogram ☐ DEXA

Region _____ Views requested _____

Side ☐ Right ☐ Left ☐ Both ☐ Not applicable

Contrast ☐ Without ☐ With ☐ Radiologist to decide

Safety check

Possible pregnancy ☐ No ☐ Yes ☐ Not sure ☐ Not applicable

First day of last period _____ Contrast allergy _____

Kidney function (if contrast) _____ Pacemaker, implants or metal _____

Clinical question

What do you want this examination to tell you? A clear question gets a clearer report.

Provisional diagnosis _____

Previous imaging

Type _____ Date _____

Where _____ Attached (yes / no) _____

Priority ☐ Routine ☐ Soon ☐ Urgent

Send results to ☐ Patient's WhatsApp ☐ Email ☐ The clinic

Doctor's name and signature

Stamp

Date and time

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