



PLEASE PLACE BARCODE HERE



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REFERRING DOCTOR		DR E LANE		P2421		COPY DOCTOR	
PATIENT DETAILS				PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT			
HAVE YOU VISITED ANY OF OUR BRANCHES BEFORE? <input type="checkbox"/> Y <input type="checkbox"/> N							
ID NO				SURNAME & INITIALS			
SURNAME				LANGUAGE		E <input type="checkbox"/> A <input type="checkbox"/>	
INITIALS & FIRST NAME				TITLE			
DATE OF BIRTH		D D M M Y Y Y Y		SEX		M <input type="checkbox"/> F <input type="checkbox"/>	
HOSPITAL/ FOLIO NO.				EMPLOYER			
-ATTENT				E-MAIL			
I give consent for tests and guarantee payment of any amounts. I verify that all information is correct		PATIENT SIGNATURE:		MEDICAL AID			
HOSPITAL PATIENT		<input type="checkbox"/> Y <input type="checkbox"/> N		MEDICAL AID/ RECEIPT/ COJ NO.			
COLL. DATE		D D M M Y Y Y Y		AUTHORISATION NO.		DEP. CODE	
COLL. BY				PATIENT MEMBERSHIP CARD VERIFIED		<input type="checkbox"/> Y <input type="checkbox"/> N	
SPECIAL INSTRUCTIONS		FAX		ACCOUNT NUMBER			
PRIORITY		ROUTINE <input type="checkbox"/> URGENT <input type="checkbox"/> STAT <input type="checkbox"/>		SPEC. CONTAINER:		MRI NUMBER	

SHORT LOG

DH 40 Handling fee.

Urgent collection

Routine collection

C: Do not log any tests.

C: Please send all specimens to:
Send Away Lab
614 Pretorius Street
Arcadia, Pretoria
Attention: Engela Claassen (012 - 427 1800)

C: Any comments about the specimen to be sent to emily.lane@hixnet.co.za