**URINE REQUEST** **IF THE FORM IS NOT COMPLETED WITH NAME, D.O.B. AND SYMPTOMS, IT WILL NOT BE TESTED**

**SAMPLES/FORMS MUST BE RECEIVED BY 12 NOON** **URINE WILL NOT BE TESTED UNTIL AFTER 12 NOON**

**PLEASE TELEPHONE AFTER 4.00 P.M. FOR RESULT**

**FULL NAME:** _____ **D.O.B:** _____

**Please tick as appropriate:**

| SELF-REFERRAL | SYMPTOMS | | REQUIRED INFORMATION | |
|---|---|---|---|---|
| | Going more often: | | Are you pregnant? | **YES:** ❒ **NO:** ❒ |
| | Pain passing urine: | | Have you had a urine infection | |
| | Blood in urine: | | in the last three months? | **YES:** ❒ **NO:** ❒ |
| | Generally unwell: | | Is this a sample from a child? | **YES:** ❒ **NO:** ❒ |
| | Other: | | Do you have catheter in-situ? | **YES:** ❒ **NO:** ❒ |
| | (Please state below) | | | |

**PLEASE ENSURE SAMPLE IS WRAPPED AND COVERED**