



PATIENT DETAILS	
Patient Name: _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
DOB _____	MRN _____
Consultant _____	

SPECIMEN DETAILS
Body site: _____
Specimen number: _____
Specific clinical query/details: _____
_____
_____
_____

PHOTO ATTACHED: YES  NO

RELEVANT MEDICAL HISTORY
_____
_____
_____

OUTCOME DETAILS
_____
_____
_____
_____