



SAS REFERRED THYROID FUNCTION TESTING

For use by Addenbrooke's Hospital Lab only

Referring Hospital and Address for reports	Patient Details	
	Surname:	
	First name:	
	D.O.B.	Sex
	NHS No.	
Referring Dr.	Referring Hospital Patient No.	
Referring Dr. signature	Referring Hospital Lab No.	
Contact telephone no.	Sample Date	

Previous referral for investigations of abnormal TFT	
If Yes please give previous Addenbrooke's Hospital Specimen Number, or date, of previous sample, if known.	

Clinical Details (e.g. drugs (thyroid and others), current clinical details, brief medical history). Please attach further summary sheets if necessary. Also details of any previous interference studies performed.

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Drugs Delete as appropriate and provide details of the dose	No drug information available
Thyroxine	T3
Carbimazole	Amiodarone
PTU	Heparin
Other drugs and dose (please list)	

Referring laboratory results, including instruments and reference ranges. Include results from other assays such as Total T4, TPO, TRAb, SHBG, alpha subunit, and attach further summary sheets if necessary.

Date				Reference range
Instrument				
TSH				
Free T4				
Free T3				

Analysis required If specific assays and work required please state, otherwise please leave blank and the work done will be based on the details and results provided.

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