

Royal Centre for Disease Control
Department of Public Health
SAMPLE REFERRAL FORM FOR CONFIRMATION

Name of the Health facility:			
Patient Information			
Name:		Age/Sex:	
Laboratory Information			
Sample ID:			
Date of collection:		Date of shipment:	
<u>Test Kit(s) used:</u>	<u>Lot No.:</u>	<u>Expiry date:</u>	<u>Test result:</u>
1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Tested by (Name and signature): _____ Test date: _____			
Name, designation, contact add of the person to be notified: _____			
This section is to be Filled by RCDC Only			
Received by: _____		Date: _____	
Sample condition:			
Good: _____			
Not good, specify: _____			
New sample ID:			
<u>Test kit(s) used:</u>	<u>Lot No.:</u>	<u>Expiry date:</u>	
1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	
Result:		Interpretation:	
Analyzed by (Name and signature): _____		Test date: _____	
Notified to: _____			
Notified by: _____		Date: _____	

Note: Samples should be shipped frozen or at 2-8°C