MANDATORY CLINICAL INFORMATION FORM FOR VITAMIN D

If this form is incomplete or not enclosed with a separate serum sample, analysis will NOT proceed for Vitamin D testing and the sample will be discarded. Dr signature and MCRN required.
*** indicates mandatory field (request rejected if not provided)**

Patient Details *

MRN___________________________________

Surname ____________________ Forename ______________

D.O.B. ______________________ Sex ________________

Address: ____

UHL Lab No.

1 Separate Serum Sample required

Requester's Details

GP Name *: _______________________

Doctor's Signature * _______________________________________

MCRN * _______________

Vitamin D is **NOT** available for routine screening of asymptomatic adults. Please refer to HSE guidelines on Vitamin D measurement
https://www.hse.ie/eng/about/who/cspd/lsr/resources/indications-for-measurement-of-vitamin-d-levels.pdf

	All questions MUST be answered in full. Requests failing to meet the relevant criteria will not be processed.	**Yes/No ***	**Date of previous request ***	**Previous result ***
1	**Is this a repeat request ?** (if previous result is within 6 months, please do not proceed as sample will NOT be processed. Please refer to HSE guidelines for retesting recommendations.)			

		Yes/No *	**Provide specific details*:**
2	Is this request related to **Metabolic Bone Disease?**		
3	Is this request resulting from **Biochemical findings related to abnormal Vitamin D levels?** **Raised Alkaline Phophatase with otherwise normal liver function, Hyperparathyroidism, Hypo or Hypercalcaemia, Hypophospataemia.**		When was the biochemical abnormality identified? __/__/____