

REQUEST FOR GROUP B STREPTOCOCCUS SCREENING

Date Received:

PATIENT DETAILS

Surname:	_____	Address	_____
Forenames:	_____	Name:	_____
	_____	Address:	_____
	_____		_____
Date of Birth:	_____	Post Code	_____
Clinical No:	_____	e-mail	_____
Date & Time	_____	Tel:	_____
swabs sampled	_____	Mobile:	_____
	_____	Receive results by Text? Yes/No	_____

MIDWIFE/CONSULTANT

Name:	_____
Address:	_____

Post Code	_____
Fax:	_____
e-mail	_____

Clinical Details

Allergy to Penicillin? Yes No

Gestation _____ weeks

Swabs Taken: Low Vaginal
 Rectal

Payment Details: The cost of the screening test is £32.00 and payment must accompany this request. Please tick and complete details below:

- I enclose Cheque No _____ for £32.00 made payable to Mullhaven Medical Laboratory
- I authorise Mullhaven Medical Laboratory to debit the sum of £32.00 from my Debit/Credit card as detailed below:

Card Type: Mastercard Visa Visa Electron Switch/Maestro/Solo

Card Holder's Name _____ Card No: _____

Start Date _____ Expiry Date _____ Issue No (Switch/Maestro/Solo) _____

Security No (Last 3 digits on signature strip) _____

Date: _____ Cardholder's Signature