

Department of Pathology, Our Lady's Hospital Navan

LF-BIO-0109 Rev 01	Vitamin B12 /Folate Request Form	Page 1 of 1 Effective Date: 01/12/2022
Author: Dervla O'Malley		Authoriser: Dr Paula O'Shea

Please complete this form for ALL Vitamin B12/Folate requests and enclose with each sample, to enable timely analysis. **From 01/12/2022, if this form is incomplete or not enclosed with the sample, usual analysis will NOT proceed.** The sample will instead be retained for 3 days from the date of sample collection and will be analysed only in exceptional circumstances, upon receipt of such details by the laboratory (contact details at bottom) AND following communication with the Consultant Clinical Biochemist. During this time if there has been no such correspondence, samples will be discarded without analysis. This form must accompany all requests for Vitamin B12/Folate testing.

Please affix patient label here or complete box below

Name: Gender: Date of Birth: Address: Hospital Number:
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Requestor's details

Name: _____ Source: _____

Request Details Has Vitamin B12/Folate been requested on this patient before? Yes / No (circle as applicable)

• If Yes: When was the last sample analysed? ____/____/20____

What is the reason for this request (complete below as relevant, giving specific details):

- High risk for nutritional B12/Folate deficiency? _____
- High risk for drug related B12/Folate deficiency? _____
- GI disease/surgery or related features? _____
- Unexplained hematologic abnormalities? _____
- Unexplained neurologic abnormalities? _____
- Consultant Haematologist/Neurologist management? (Circle as relevant)
- Other supportive signs (e.g. glossitis, mouth ulceration) _____
- Pregnancy? Yes/No
- Dialysis patient? Yes/No

LAB USE ONLY: Received Date and Time stamp: