Surname Forename		WRH-HIS-LF
	Autoantibody Request 1 Serum sample (Yellow Cap) required for	Laboratory Use Only
Forename	the following tests Anti-Nuclear Antibody Screen	Laboratory Number here Laboratory Use Only
	(includes anti-nuclear ab., anti-mitochondrial ab., anti-smooth muscle ab., anti-liver kidney microsomal a & anti-parietal cell ab.)	b.
Date of Birth	Coeliac Screen (anti-tissue transglutaminase IgA ab.)	Laboratory Number here Laboratory Use Only
Consultant Female Ma		
Ward/Hospital		Laboratory Use Only - Test Codes
Apply addressograph label here or insert address here. Do not use rubber stamp.	a	
IMPORTANT: This form is electronically scanned. Select lests by filling the appropriate box fully or by		
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