PATIENT RECEPTION AT:
THE DOCTORS LABORATORY
76 Wimpole Street, London W1G 9RT
Monday to Friday 7.00am–7.00pm
Saturday 7.00am–1.00pm
Main Tel: 020 7307 7373
Out of hours samples may be dropped at 76 Wimpole St

CLINICIAN

SOURCE

Doctor

Address

Tel

Email

Additional copy of results to:

SURNAME				DOB		When completing this form please provide at least three unique identifiers for your patient.
FORENAME		TITLE		M/F		

Patient Ref/ID No.

TEST

■ **ENDT Ziwig Endotest** **Self-collect Endotest saliva collection kit**

TAP5557E/17-07-26/V11

REQUIRED INFORMATION FOR ELIGIBILITY PROVIDED BY THE PATIENT

Samples will be rejected if:

- Your age is not within 18 years and 43 years
- You have a history of cancer, or HIV, or are pregnant
- The saliva collection device is outside the use-by date

Please place Ziwig barcode here

Do you have clinical signs of endometriosis and/or infertility?	☐ Yes	☐ No	Samples will only be accepted if Yes is selected
Do you have a history of cancer?	☐ Yes	☐ No	If the answer is Yes to any of these questions, testing will not be possible
Do you have a history of HIV?	☐ Yes	☐ No	
Are you pregnant?	☐ Yes	☐ No	
Has the saliva been collected in the morning?	☐ Yes	☐ No	Morning collection is preferred, but not essential
Has the sample been collected at least 30 mins after eating, drinking, brushing teeth, smoking or chewing gum and without having applied lipstick?	☐ Yes	☐ No	Samples will only be accepted if Yes is selected
Can you please confirm that you do not currently have an ear, nose or throat infection? (tick Yes if you do not have an infection)	☐ Yes	☐ No	
Have you checked that the sample does not contain blood, has sufficient volume of saliva and the collection tube is within its expiry date?	☐ Yes	☐ No	
Has the sample been collected at room temperature (within 20-26 degrees C)?	☐ Yes	☐ No	

Sample date and time: D D M M Y Y Y Y H H M M

Expiry date on tube checked? Date of expiry: D D M M Y Y Y Y

I have confirmed that the use by date for the saliva collection device has been confirmed as within date

Ensure that the sample is labelled with patient name and DOB using the label provided, without obscuring the fill line or covering the barcode.

Please complete and confirm this information, unlabelled or expired tubes will be rejected.

☐ Fee to be paid by Patient/Other. **PLEASE PROVIDE ADDRESS DETAILS** ☐ XPOS ☐ MPOS

Insurance Co. Membership No.

Patient address

Postcode Contact telephone number

☐ Fee to be paid by Doctor/Clinic as above

Signature _____

For Practice Use Only:						For Laboratory Use Only:						For Patient Service's Use Only:			
EDTA	SST	GREY	MSU	OTHERS	INITIALS	EDTA	SST	GREY	MSU	OTHERS	INITIALS	TIME IN R	TIME IN Ph	TIME OUT Ph	TAKEN BY INITIALS

THE DOCTORS LABORATORY