

IMMUNOFLUORESCENCE (IMF) REQUEST FORM

Red boxes indicate essential information. Any red box fields left blank may result in delays to specimen processing

<p>SURNAME</p> <p>Forename</p> <p>DoB / / M F</p> <p>Patient No.</p> <p>NHS No. (OR AFFIX PATIENT INFORMATION LABEL HERE)</p>	<p>Report destination:</p> <p>Dept</p> <p>Address</p> <p>Email@nhs.net</p>
<p>NHS patient <input type="checkbox"/> Private patient <input type="checkbox"/> →</p>	<p>Billing address (PRIVATE PATIENTS ONLY):</p> <p>..... </p> <p> <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Insurance Co. </p>
<p>Hospital/Centre (PLEASE DO NOT USE ABBREVIATIONS)</p> <p>Requesting clinician</p>	

Clinical information: (include history and any relevant medications)

Differential diagnoses?

Specimen information:

Date taken: / /

<input type="checkbox"/> Biopsy	No. of biopsies: 1 2 3
Biopsy 1 site:	Lesional <input type="checkbox"/> Peri-lesional <input type="checkbox"/> Normal <input type="checkbox"/>
Biopsy 2 site:	Lesional <input type="checkbox"/> Peri-lesional <input type="checkbox"/> Normal <input type="checkbox"/>
Biopsy 3 site:	Lesional <input type="checkbox"/> Peri-lesional <input type="checkbox"/> Normal <input type="checkbox"/>

<input type="checkbox"/> Serum* <input type="checkbox"/> Blister fluid	}	<input type="checkbox"/> Indirect immunofluorescence <input type="checkbox"/> DSG1/3 ELISA (pemphigus)	*Please send 1x gold top serum separator tube (SST)
		<input type="checkbox"/> BP180/230 ELISA (pemphigoid)	<input type="checkbox"/> COLVII ELISA (EBA)