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| **Clinical Chemistry Laboratory TUH**  **Vitamin D Request Form** | |
| **From 03/03/2025, if this form is incomplete or not enclosed with the sample, analysis will NOT proceed for Vitamin D testing and the sample will be discarded.**  **NB: Routine screening of asymptomatic adults (including pregnant women) for Vitamin D deficiency is NOT currently recommended. Please do NOT request the test if the patient is not in the subgroup of individuals considered at risk of Vitamin D deficiency (see HSE Advice note** [**https://www.hse.ie/eng/about/who/cspd/lsr/resources/advice.html**](https://www.hse.ie/eng/about/who/cspd/lsr/resources/advice.html) | |
| ***1 separate Serum sample required***  **Patient Information or Addressograph**  Hospital No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ | **TUH Laboratory Number** |
| **Requester’s details:**  General Practitioner name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Address/Stamp:  TUH LAB CODE: ­­­­­­­­\_\_\_\_\_\_\_  Doctor’s signature: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice Telephone number: \_\_\_\_\_\_\_\_\_\_\_ | |
| **Please complete the Mandatory Request Information table on the next page** | |

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| **Mandatory Request Information** | |
| **1. Is the request related to monitoring response to Vitamin D treatment?** | YES / NO (circle as appropriate)  If YES, please specify when the last sample was analysed? \_\_\_\_/\_\_\_/20\_\_\_\_\_\_ |
| **NB: Serum 25OH-D levels should NOT be retested earlier than 3 months following commencement of supplementation with Vitamin D or change in dose. Samples breaching this rule will be discarded.** | |
| **2. Is the request related to one or more of the following conditions (provide specific details)** | * Metabolic Bone Disease? (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Biochemical findings related to abnormal Vitamin D levels e.g., increased alkaline phosphatase with otherwise normal liver function tests, hyperparathyroidism, hypo- or hypercalcaemia, hypophosphatemia? YES / NO (circle as appropriate)   If YES   * + Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   + When was the biochemical abnormality identified?        \_\_\_\_/\_\_\_/20\_\_\_\_\_\_ |
| **Other relevant medical conditions, medications or features that could be attributed to or lead to abnormal vitamin D status. (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Please note that requests failing to meet the relevant criteria will not be processed** | |