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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\_\_\_\_\_\_
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| **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** |