



MYCOLOGY REQUEST FORM

Send to:

Mycology Department,
St. John's Institute of Dermatology,
St. Thomas's Hospital,
Westminster Bridge Road,
London,
SE1 7EH

Requester:

Details of Patient: (Please complete in BLOCK letters.)

Surname:			
First Name:			
Hospital /NHS Number:			
Date of Birth:		M / F :	
Country of Origin:			
Previous Mycology No:			
Provisional Diagnosis and Relevant History:			

Sites to be examined:

Date Specimen Taken:	
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Date: _____

Signature: _____