Antimicrobial Reference Laboratory

Severn Infection Sciences Partnership, North Bristol NHS Trust

Tel: 0117 41 46220 / 46269	Email: ARLEnquiries@nbt.nhs.uk

REQUEST FOR THERAPEUTIC DRUG MONITORING

PATIENT DETAILS - *Essential information*

Surname (capitals)		**Forename(s)**	
Date of Birth		**Sex***	**M/F**
Assay required		**Biohazard***	**Y/N**

Additional information (optional)

Hospital/NHS number	
Antibiotic dose	
Frequency	
Duration of treatment	
Condition being treated	
Any significant pathology	
Purchase Order Number	

**delete as appropriate*

SAMPLE DETAILS

Current date		Sample type		Date collected	

Total number of samples enclosed for this patient			
Sample*	Reference number	Differentiated*	Timing of sample
1		Pre/post/random	
2		Pre/post/random	
3		Pre/post/random	
4		Pre/post/random	
5		Pre/post/random	

**delete as appropriate*

SOURCE LABORATORY DETAILS

Department			
Hospital			
Address#			
		Postcode	
Please phone (direct number) or fax^ my result to the following number			

#Please also supply billing address if different *^This must be a secure fax terminal*

FOR REFERENCE LABORATORY USE