



## MYCOLOGY REQUEST FORM

**Send to:**

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

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**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:	

Date: .....

Signature: .....