

Mycology Specialist Dermatology Laboratories St Thomas' Hospital Westminster Bridge Road London SE1 7EH

Tel: 020 7188 6400

Mycology Request	Lab. Ref.	No:
Sent by:		Patient:
Signature.		Surname:
		Forename:
Print Name.		Date of Birth:
Return address:	Guys	Hospital Number:
	St T	Previous Mycology Number:
Date:		
Provisional Diagnosis and Relevant History:		Sites to be Examined: (Please be specific.)
Date Specimen Taken:		

DIRECT EXAMINATION:

Date:

CULTURE RESULT:

Signature:

Date:

Signature:

Internal Request Form

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Author: Martin Cunningham

Authorised by: Lucy Hillman-Ment