Methotrexate Assay

Haematology Department
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PLEASE ENSURE ALL FIELDS OF THIS FORM ARE COMPLETE

Patient details

GOS number	G -			Referring hospital	
Surname				Contact number	
Forename				NHS number	
Date of birth		Sex	M / F	Hospital number	
				Lab number	

Specimen details

2ml EDTA blood

Date		Time	

Number of hours post end of methotrexate infusion

24 48 72 96 other_____

Is the patient high risk? Y N

Address for return of results and invoice

Invoice/order number:

Laboratory service 0207 405 9200 extn 5390

Mon – Fri	Specimen must arrive by **14:00** Please telephone for results after **18:00**
Weekend & Bank holidays	**By prior arrangement only** Specimen must arrive by **11:00** Please telephone for results after **15:00**

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