



FOR INTERNAL USE ONLY

Date Received:

iQur ID No:

ELF ANALYSIS REQUEST FORM

REQUESTING CENTRE:	PLEASE TICK HERE IF THIS TEST REQUEST IS URGENT <input type="checkbox"/>
SITE ID / ACCOUNT NO (IF APPLICABLE):	
REQUESTING DOCTOR / NURSE:	
CONTACT DETAILS:	
PATIENT NAME:	PATIENT REFERENCE NUMBER: (NHS / laboratory / clinical study reference number)
DATE OF BIRTH:	
SAMPLE TYPE: SERUM (<i>Only serum is accepted for ELF test</i>)	
DATE AND TIME OF SAMPLE COLLECTION:	
FOR SAMPLES OLDER THAN 24 HOURS, PLEASE DESCRIBE HOW IT HAS BEEN STORED SINCE COLLECTION:	
TEST(S) REQUIRED:	
ENHANCED LIVER FIBROSIS TEST (ELF™): <input type="checkbox"/>	
CLINICAL DETAILS / TREATMENT ETC:	

For further information, please visit our website www.iqur.com or call 020 7636 8219 or email richard.cross@iqur.com