



HOSPITAL SUPPORT DIAGNOSIS CENTRE

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Digital X-Ray | 4- D Scan | E.C.G. | Echocardiography | Mammography | Comprehensive Medical Laboratory

REFERRAL FORM

URGENT ROUTINE
DATE

PATIENT DETAILS

Patient's Name _____

Phone No/Email _____

Clinical Details & Diagnosis _____

DATE OF BIRTH _____ LMP _____

AGE _____ GENDER M F

SUBMITTED Y N

COLLECTION DATE

D	D	M	M	Y	Y	Y	Y
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 TIME HOUR _____ MIN _____

SPECIMEN RECEIVED

D	D	M	M	Y	Y	Y	Y
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 TIME HOUR _____ MIN _____

REFERRING DOCTOR'S DETAIL

Referral Doctor _____ Phone No _____

Hospital _____

Bill to: Patient Hospital Company/HMO Company/Hospital Name: _____ Enrollee No: _____

Preliminary Report Request: Yes No Final Report Sent to: Doctor Patient

PATHOLOGY

BIOCHEMISTRY HEAMATOLOGY ENDOCRINOLOGY SEROLOGY MICROBIOLOGY

RENAL/ELECTROLYTES/BONE

- E/U/CR
- ELECTROLYTE
- SODIUM
- POTASSIUM
- UREA
- CREATININE
- CREATININE CLEARANCE (24 hr urine)
- PROTEIN
- URIC ACID
- MAGNESIUM
- CALCIUM (No tourniquet)
- PHOSPHATE
- ALBUMIN
- MICROALBUMIN (Urine/ quantitative)

LIVER / PANCREAS

- LFT (Liver Function Test)
- LIVER ENZYMES ONLY
- PROTEIN ELECTROPHORESIS
- IMMUNOFIXATION (Serum)
- PROTEIN TOTAL / ALBUMIN
- BILIRUBIN
- ALP
- GGT
- AST
- ALT
- AMYLASE
- LIPASE

DIABETES

- GLUCOSE (fasting)
- GLUCOSE (Random)
- GLUCOSE post prandial (24hrs)
- GLUCOSE TOLERANCE TEST (2hrs)
- HnA1c
- INSULIN

LIPIDS / CARDIAC RISK

- LIPID PROFILE
- CHOLESTEROL - TOTAL
- TRIGLYCERIDES
- HDL
- LDL

CARDIAC

- MYOGLOBIN
- TROPONIN 1
- TROPONIN T
- CK

INFLAMMATION / IMMUNE

- CRP
- COMPLEMENT C3/C4

HEAMATOLOGY

- FBC/CBC
- ESR
- PCV
- PLATELET COUNT
- HAEMOGLOBIN
- WBC DIFF COUNT
- PERIPHERAL BLOOD FILM
- RETICULOCYTES COUNT
- IRON STUDIES
- FERRITIN
- TOTAL IRON BINDING CAPACITY (TIBC)
- RDC FOLATE
- FOLIC ACID
- VIT B12
- Hb ELECTROPHORESIS/ GENOTYPE
- ABO/RH (Blood Grouping)
- G6PD QUANT
- COOMB'S TEST (DIRECT)
- COOMB'S TEST (INDIRECT)
- MALARIA
- BONE MARROW ASPIRATION

COAGULATION

- PT/INR
- PTTK
- D-DIMER
- PROTEIN C
- PROTEIN S
- FACTOR VIII

DRUG

DRUG SCREEN

- DRUG SCREEN PANEL (5 DRUGS)
- DRUG SCREEN PANEL (7 DRUGS)
- DRUG SCREEN PANEL (10 DRUGS)
- OPIATES
- COCAINE
- CANNABIS
- ALCOHOL
- AMPHETAMINE
- BARBITURATE
- BENZODIAZEPINES
- PHENCYCLIDINE

DRUG MONITORING
Please specify others drugs

OTHERS

- DNA PATERNITY
- TOTAL Igt

Others please specify

ENDOCRINE-THYROID

- THYROID FUNCTION TEST (T3, T4, TSH)
- TSH
- FREE T4
- FREE T3
- THYROGLOBULIN AB
- TPO

ENDOCRINE-REPRODUCTIVE

- SEMEN ANALYSIS
- B-HCG quantitative
- HORMONE PROFILE
- PROGESTERONE
- FSH
- LH
- ESTRADIOL (E2)
- PROLACTIN (rest 15 minutes)
- DHEA-S
- TESTOSTERONE (Total)
- TESTOSTERONE (Free)
- ANTI MULLERIAN HORMONE

HYPERTENSION/ OTHER ENDOCRINE

- RENIN/ALDOSTERONE
- CORTISOL (serum)
- CORTISOL (24hr urine)
- GROWTH HORMONE
- ACTH
- ANTI DIURETIC HORMONE (ADH)

TUMOUR MARKERS

- PSA (Total)
- PSA (Free)
- CEA (G.I.T, lung, breast)
- CA 19-9 (G.I.T, pancreas)
- CA 125 (ovary)
- CA 15-3 (breast)
- CA 72-4 (G.I.T)
- AFP
- B2 MICROGLOBULIN
- OCCULT BLOOD (stool)
- BENCE JONES (urine)

AUTO IMMUNE

- ANCA
- ANE ANTI ONA (ds DNA) FENA
- ANTIPHOSPHOLIPID AB
- CARDIOLIPIN AB
- LUPUS ANTICOAGULANT

INFECTIVE

- WIDAL
- CMV AB (IgG, IgM)
- CAV VIRAL LOAD
- RUBELLA IgM
- RUBELLA IMMUNITY (IgG only)
- TOXOPLASMA IgM
- HUMAN PAPILLOMA VIRUS (HPV)
- H. PYLORI Ab
- RPR/VDR
- TPHA (syphilis)
- CHLAMYDIA Trachomatis Ab
- HERPES SIMPLEX I & II (IgM/IgG)
- MUMPS ELISA IgG/IgM
- MEASLES Ab
- TORCH SCREEN

HEPATITIS TEST

- HAV
- HbsAg
- HbsAg Total
- Hepatitis B. Virus Panal
- HCV
- HEPATITIS B DNA VIRAL LOAD
- HEPATITIS C RNA VIRAL LOAD
- HEPATITIS B VIRUS (HBV)
- GENOTYPE
- HCV RNA GENOTYPE

HIV TESTS

- HIV SCREENING
- HIV CONFIRMATION
- HIV VIRAL LOAD
- Cd4
- P24 ANTIGEN+HIV & IIAb

HISTOPATHOLOGY

- HISTOLOGY ONLY
- HISTOLOGY WITH IMMUNOHISTOCHEMISTRY *S-SMALL L LARGE

CYTOLOGY

- PAP SMEAR (Conventional)
- PAR SMACAM
- FINE NEEDLE ASPIRATION CYTOLOGY (FNAC)

- CSF CELL COUNTY + CHEMISTRY
- CFS MC & S CELL COUNT + CHEMISTRY

URINE

- URINE MICROBIOLOGY
- URINE CHEMISTRY
- URINALYSIS
- URINE REDUCING SUBSTANCES
- URINE MC&S

STOOL

- STOOL ANALYSIS (Adult)
- STOOL ANALYSIS (PAEDIATRIC) (ADENO/HOTAVIRUS)
- STOOL MC&S
- FAECAL OCCULT BLOOD
- H. PYLORI ANTIGEN
- REDUCING SUBSTANCES
- BLOOD MICROSCOPY (Parasites)
- MALARIA PARASITE

SPUTUM/B

- SPUTUM MC&S
- SPUTUM ZN SMEAR (for AFB)
- ZN SMEAR OF ASPIRATES/URINE (for AFB)

TB CULTURE ONLY

- TB CULTURE ONLY
- TB SENSITIVITY 1ST LINE
- TB SENSITIVITY 2ND LINE
- TB PCR
- MANTOUX
- TB QUANTIFERON
- RESPIRATORY VIRUS PANAL

FUNGAL/YEAST

- FUNGAL MICROSCOPY
- FUNGAL CULTURE

OTHER MICROBIOLOGY TESTS

- MC&S
- MICROSCOPY ONLY SPECIMEN

MOLECULAR BIOLOGY PCR

- PCR HIV (Quantitative)/VIRAL LOAD
- PCR HIV-1 DNA (Quantitative)
- PCR HIV (Quantitative)
- PCR HEPATITIS B ONA VIRAL LOAD
- PCR HEPATITIS C RNA VIRAL LOAD
- PCR ACE (ADENO+CMV+EBV) VL
- PCR CHLAMYDIA PNEUMONIA
- PCR CHLAMYDIA
- TRACHONOMAS

Others (please specify) _____

WE OPEN EVERYDAY & ON PUBLIC HOLIDAYS EXCEPT SUNDAYS

RADIOLOGY

Selected body parts and specify in the space below:

DIGITAL X-RAY (ROUTINE)

- | | | | |
|---|--|---------------------------------|---|
| <input type="checkbox"/> CHEST (PA only) | <input type="checkbox"/> THORACIC SPINE (PA & LAT) | <input type="checkbox"/> ARM | <input type="checkbox"/> THIGH |
| <input type="checkbox"/> CHEST (PA & LAT) | <input type="checkbox"/> THORACOLUMBAR | <input type="checkbox"/> ELBOW | <input type="checkbox"/> KNEE |
| <input type="checkbox"/> ABDOMEN (supine) | <input type="checkbox"/> ANKLE JOINT | <input type="checkbox"/> FOREAM | <input type="checkbox"/> LEG |
| <input type="checkbox"/> LUMBO-SACRAL | <input type="checkbox"/> SKULL (all views/specify) | <input type="checkbox"/> HAND | <input type="checkbox"/> FOOT |
| <input type="checkbox"/> ABDOMEN (erect & supine) | <input type="checkbox"/> SKULL (AP/LAT) | <input type="checkbox"/> PELVIS | <input type="checkbox"/> PARANASSAL SINUSES |
| <input type="checkbox"/> CERVICAL SPINE (all views) | <input type="checkbox"/> SHOULD | <input type="checkbox"/> HIP | <input type="checkbox"/> POST-NASAL SPACE |

Others please specify _____

DIGITAL X-RAY (SPECIAL)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> HYSTERSALPINGOGRAPHY (HSG) | <input type="checkbox"/> MCUG & RUCG | <input type="checkbox"/> BARIUM ENEMA |
| <input type="checkbox"/> ANAESTHESIA | <input type="checkbox"/> INTRAVENOUS UROGRAPHY | <input type="checkbox"/> LOOPOGRAM |
| <input type="checkbox"/> HYSTERSALPINGOGRAPHY (HSG) | <input type="checkbox"/> BARIUM SWALLOW | <input type="checkbox"/> FISTULOGRAM |
| <input type="checkbox"/> MCUG | <input type="checkbox"/> BARIUM MEAL | <input type="checkbox"/> SINOGRAM |
| <input type="checkbox"/> RUCG | <input type="checkbox"/> BARIUM MEAL & FOLLOW THROUGH | <input type="checkbox"/> VAGINOGRAM |

Others please specify _____

ULTRASOUND SCAN

- | | | |
|--|--|---|
| <input type="checkbox"/> 2D OBSTETRIC ULTRASOUND | <input type="checkbox"/> FOLUCLE MONITORING | <input type="checkbox"/> SMALL PARTS ULTRASOUND |
| <input type="checkbox"/> 4D OBSTETRIC ULTRASOUND | <input type="checkbox"/> KUB ULTRASOUND | <input type="checkbox"/> SOFT TISSUE ULTRASOUND |
| <input type="checkbox"/> OBSTETRIC ULTRASOUND
+ BIOPHYSICAL PROFILE | <input type="checkbox"/> TRANSRECTAL (Prostate) ULTRASOUND | <input type="checkbox"/> CHEST ULTRASOUND |
| <input type="checkbox"/> ABDOMINAL ULTRASOUND | <input type="checkbox"/> TRANVAGINAL ULTRASOUND | <input type="checkbox"/> ULTRASOUND GUIDED BIOPSY (Specify) |
| <input type="checkbox"/> PELVIC ULTRASOUND | <input type="checkbox"/> SCROTAL ULTRASOUND | <input type="checkbox"/> ULTRASOUND GUIDED FNAC |
| <input type="checkbox"/> MUSCULESKELETAL ULTRASOUND | <input type="checkbox"/> OCULAR ULTRASOUND | <input type="checkbox"/> ULTRASOUND GUIDED ABSCESS DRAINAGE |
| | | <input type="checkbox"/> ULTRASOUND GUIDED CYST DRAINAGE |

Others please specify _____

VASCULAR / DOPPLER STUDIES

- | | | |
|---|---|---|
| <input type="checkbox"/> LOWER EXTREMITY (Arterial) | <input type="checkbox"/> UPPER EXTREMITY (Verous) | <input type="checkbox"/> HEPATIC (Liver) |
| <input type="checkbox"/> LOWER EXTREMITY (Verous) | <input type="checkbox"/> CAROID | <input type="checkbox"/> TRANSCRANIAL |
| <input type="checkbox"/> UPPER EXTREMITY (Arterial) | <input type="checkbox"/> RENAL (Kidney) | <input type="checkbox"/> UMBILICAL ARTERY DOPPLER |

Others please specify _____

CARDIAC TEST

ECG | PAEDIATRIC ECG | STRESS ECG | ECHOCARDIOGRAPHY

BREAST IMAGING

DIGITAL MAMMOGRAPHY | BREAST SCAN | DUCTOGRAPHY

HEALTH CHECK PLANS 

BRONZE

SILVER

GOLD

HEART DISEASE