

MYCOLOGY REQUEST FORM

Send to:

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

Requester:

--

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: