



Blood Test Review

To be used when blood test results **ONLY** are being submitted (i.e., when a valid Annual Medical is already in place.) Please return **WITH COPIES OF LABORATORY RESULTS** to: contact@ausmma.com.au

Competitor Name: _____

Medical ID Number (NHS/CHI Registration number): _____

Date of birth: _____

Telephone number: _____

Email address: _____

Postal address: _____

Name of Reviewing Doctor: _____

Qualifications: _____

Doctor Registration Number: _____

Practice address: _____

Telephone number: _____

Email address: _____

NOTE TO DOCTOR: Please counsel all competitors prior to arranging phlebotomy.
Interpretation must be accompanied by copies of laboratory results sent back with this form.

HEPATITIS B	Tested within the last 6 months ?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date of sample:		Clear from infection?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

HEPATITIS C	Tested within the last 6 months ?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date of sample:		Clear from infection?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

HIV (Dual Antigen Test)	Tested within the last 6 months ?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date of sample:		Clear from infection?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Signed (Doctor): _____

Date: _____