MediFast Medical Centre
Mobile Phlebotomy Service Fax Order Form

To: **MEDIFAST MEDICAL CENTRE**
No. 10 Sinaran Drive
#11-27,28 & 29
Singapore 307506

Tel: 6222 3373
Fax: 6222 0090
Email: singapore@medifast.com

PART 1: CLINIC'S PARTICULARS

Full Name of Doctor: ____

Office Phone: ______________________________________ Mobile Phone: ___________________________

Clinic's Office/Location: ____

Doctor's Instruction: Medifast to contact patient for appointment and other necessary arrangements. Yes / No

PART 2: PATIENT'S PARTICULARS

Full Name: ____ Sex: Male / Female
Surname (Underline)

Date of Birth: _______ /_______/_________ NRIC / PASSPORT: ______________________________
Day Month Year

Patient's Address: ____

____

Nearest Intersection / MRT Station:____

TAKE NOTE: A surcharge of $15 will be imposed for areas not accessible by MRT or buses.

Contact Number (Office) : __________________(Home):_________________________(Others): ___________________

PART 3: TYPE OF SERVICES REQUIRED

Types of Blood Test Required:

1)________________________________	5)________________________________
2)________________________________	6)________________________________
3)________________________________	7)________________________________
4)________________________________	8)________________________________

Types of Urine Test Required:

1)________________________________
2)________________________________
3)________________________________
4)________________________________

SPECIAL INSTRUCTIONS (if any): ____________________ overweight / fine vein / phobia of blood taking

Preferred Service Date & Time: _______/_______/______ ________ ______/______/______ ________
Day Month Year Time Day Month Year Time

Signature of Doctor: ____ Date: ___________________________

FOR OFFICE USE

Attended by: _________________________________ Date: _________________ Time: ________________

Confirmed by: _________________________________ Date: _________________ Time: ________________

November 2011