



## PORPHYRIN REQUEST FORM

### Patient Information or addressograph

Patient's name: \_\_\_\_\_

Patient address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Ward/Clinic: \_\_\_\_\_ Hospital No. \_\_\_\_\_

### Referrer Details

Consultant's name: \_\_\_\_\_

Referrer's name: \_\_\_\_\_

Title/position: \_\_\_\_\_ EXT/Bleep: \_\_\_\_\_

Address of requesting consultant: \_\_\_\_\_

Hospital: \_\_\_\_\_

### Clinical Features (tick all that apply)

### Is patient currently symptomatic? (Y/N) \_\_\_\_\_

Acute symptoms	Cutaneous symptoms	Others:
<input type="checkbox"/> Abdominal pain (intense, poorly localised)	<input type="checkbox"/> Pain/itch/burning on sunlight exposure	<input type="checkbox"/> Tyrosinaemia
<input type="checkbox"/> Constipation	<input type="checkbox"/> Skin fragility	<input type="checkbox"/> Lead toxicity
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Blisters/vesicles on sun exposed areas	
<input type="checkbox"/> Hyponatraemia	<input type="checkbox"/> Scarring/milia	
<input type="checkbox"/> Neurological symptoms	<input type="checkbox"/> Poor healing on exposed skin	
<input type="checkbox"/> Psychiatric symptoms	<input type="checkbox"/> Hypertrichosis	
<input type="checkbox"/> Convulsions		
<input type="checkbox"/> <b>Other symptoms:</b> Please provide details below	<b>Reason for porphyria screen:</b> _____	

**Family history of Porphyria:** (Y/N) \_\_\_\_\_ (include relationship and type of porphyria)

### Specimen information:

Random urine (  )

EDTA or Li-heparin plasma (  )

Faeces (  )

EDTA whole blood (  ) (do not freeze)

Date of sample collection: \_\_\_\_\_

**ALL SAMPLES MUST BE LIGHT PROTECTED and forwarded to the address above.**

**In case of suspected acute porphyria attack a random urine sample is required to rule out an acute attack. Other samples are required to complete the porphyria work-up.**

For further information on sample requirements please refer to the [Labmed User Guide](#)