

# BLOOD TEST REVIEW FORM FOR IMMAF COMPETITORS

Please return **WITH** a copy of laboratory results to your team Medical Safety Lead as directed.

**Competitor Name:** \_\_\_\_\_

National Team: \_\_\_\_\_

Medical ID Number *(if applicable)*: \_\_\_\_\_

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.

<b>HEPATITIS B</b>	To be valid, sample MUST be dated within the 6 months prior to competition		
Date of sample:		<b>Clear from infection?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>HEPATITIS C</b>	To be valid, sample MUST be dated within the 6 months prior to competition		
Date of sample:		<b>Clear from infection?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>HIV</b> <small>MUST inc. P24 antigen and HIV 1+2 antibodies</small>	To be valid, sample MUST be dated within the 6 months prior to competition		
Date of sample:		<b>Clear from infection?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Signed (Doctor): \_\_\_\_\_

Date of review: \_\_\_\_\_