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.

HEPATITIS B	To be valid, sample MUST be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection?** **Yes** ☐ **No** ☐

HEPATITIS C	To be valid, sample MUST be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection?** **Yes** ☐ **No** ☐

HIV **MUST inc. P24 antigen and HIV 1+2 antibodies**	To be valid, sample MUST be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection?** **Yes** ☐ **No** ☐

Signed (Doctor): _____

Date of review: _____