Blood Test Review form for MMA Competitors

Please return as a scanned PDF WITH copies of laboratory results to: records@safe-mma.co.uk

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 ☐	No ☐
Date of sample:		Clear from infection?	Yes ☐	No ☐

HEPATITIS C	Tested within the last 6 months **?**		Yes ☐	No ☐
Date of sample:		Clear from infection?	Yes ☐	No ☐

HIV **(Dual Antigen Test)**	Tested within the last 6 months **?**		Yes ☐	No ☐
Date of sample:		Clear from infection?	Yes ☐	No ☐

Signed (Doctor): _____

Date: _____