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 Neg. surface antigen (HBsAg) test required	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: ____