

AFRIGLOBAL MEDICARE
Inspiring Africa

TEST REQUEST FORM

Date: 28/2/25

☐ In-Capital Letters ☐ Home Blood Collection ☐ HMO Enrollee No. _____

☐ Patients ☐ Hospital/Lab ☐ Report by E-mail ☐ 1st MD

Patient Name: Belgrumma Ayedeyi

Sex: 67 yr 1m Phone: _____

Dr's Name & Signature: Dr. Oluwole Ayetunde

E-mail: _____

Referral Name/Address: Att Ufako Janyz

Required: Lower GI endoscopy

Clinical Diagnosis & History: Lower GI bleeding

Further Investigation