Lab Ref 411.018

Sheffield Children's NHS
NHS Foundation Trust

Sheffield Diagnostic Genetics Service Payment Form

Please fill in completely for each payment to ensure that your payment is linked to your test

Name of patient:

Date of birth (dd/mm/YYYY):

Test:

Address:

Date of referral (approximate if necessary):

Referring consultant:

Institution:

Sheffield Children's NHS FT Invoice number (only if pro-forma invoice issued):

Payment by (please circle/underline payment method):

Cheque | bankers draft | credit/debit card

Please make cheques or bankers drafts payable to Sheffield Children's NHS Foundation Trust

Details of credit/debit card

Number:

Expiry date:

Security code:

Contact details of payee including telephone number and availability

Name:

Address:

Telephone number:

Please send your completed form, together with payment, to: Sheffield Diagnostic Genetics Service, Sheffield Children's NHS Foundation Trust, Western Bank, Sheffield S10 2TH ***or*** *by fax to +44 (0) 114 275 0629 (secure).*

For office use only:

Payment received:

Date:

Cleared (date):

Signed:

Emailed to admin team in SDGS (SDGS@sch.nhs.uk) yes/no

Starlims S number: