**­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**CAIRNFOLD ROAD



BRIDGE OF DON

ABERDEEN

AB22 8LD

Telephone 0345 189 7070

Dear Sir/Madam

Please complete this form to nominate a representative to receive TEST RESULTS and MESSAGES on your behalf.

**Details of Patient**

Name:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I (name as above) give consent for the below Representative to receive any test result or messages on my behalf.

Please complete the following in capital letters.

**Name of Representative** :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient** :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_