Awanui Labs

THE SCOPE

Awanui Labs Northern - Pathology news

Introduction to the Scope February 2026

Kia ora and welcome to our first Scope edition for 2026

Welcome to the first edition of Scope for 2026. We hope you were able to enjoy some time over the summer period with family and friends and have begun the year feeling refreshed.

In this edition, we share a detailed overview of upcoming changes to vitamin D testing. This article represents the culmination of a substantial body of work, developed through wide collaboration and consultation with regional laboratory leads, adult and paediatric endocrinologists including bone specialists, primary care clinical leaders, and others.

The changes align with major new international Guidelines and an extensive audit of local requesting patterns over 20 years. These vitamin D testing changes will apply across all Northern Region laboratories and have been formally endorsed by the Auckland Regional Demand Management Group, the Regional Integrated Clinical Governance Group, Primary Care Leaders, and HealthPathways.

We include an article for referrers on appropriate allergy testing which supports equitable access and aims to reduce harm from over-testing. In this edition we also provide a brief update on immunology testing from our Laboratory Manager, Saad Mansour.

We look forward to another year of collaboration and, as always, welcome feedback to ensure our services continue to meet the needs and expectations of our referrers and patients

25OH Vitamin D Testing - A change in approach

SUMMARY

- Recent expert guidelines do not support testing patients ‘at risk’ for low vitamin D (25OHD). Empiric supplementation without testing is recommended.
- Affected ‘at risk’ groups when empiric treatment is appropriate include those with low sun exposure e.g. dark-skinned persons from African or Indian subcontinents, frail institutionalised patients, elderly living indoors, highly covered persons, children (unless there is biochemical or X ray evidence for rickets), and pregnant or postpartum patients.
- There is no rigorous evidence to support routine testing, or supplementation, in healthy community-dwelling adults.
- Recommended thresholds for vitamin D ‘sufficiency’, ‘insufficiency’ and ‘deficiency’ have been withdrawn due to lack of rigorous evidence. Although local labs will continue to use these as guidance, many patients with vitamin D in the ‘insufficient/deficient’ range have no other biochemical evidence of deficiency. Testing is rarely indicated if serum calcium and ALP are normal unless there are other clear reasons with specialist endorsement.
- Locally, numbers of 25OH-vitamin D (25OHD) requests have increased markedly since previous restrictions were introduced in 2012, recently by 30% annually with no clear reason or evidence of clinical benefit. Vitamin D is an expensive test, with cost exceeding several years of supplements. Conversely, empiric supplementation is cheap, acceptable to patients and providers, and has no adverse effect on health equity.

- Detailed local audit shows repeat testing is very common (about 1/3 of all requests), but only a small minority of repeat tests (about 5-8%) have levels ≤25nmol/L. Value is particularly limited if the last result was >50 nmol/L within 2 years, with less than 1.5% of requests in primary care, and from most specialities, having a repeat result ≤25nmol/L. New international guidance also does not recommend routine repeat testing.
- After wide consultation, new guidance /restrictions on 25OHD requesting will therefore be introduced to follow best practice and efficient use of health budget resources.

A. CHANGE IN INTERNATIONAL GUIDANCE

Recent Guidelines review new evidence and strongly recommend a change in approach

A recent expert joint Guideline statement by the US and European Endocrine Societies strongly questions the scientific rationale for testing 25OH vitamin D in so-called 'at risk' groups, and recommends empiric supplementation without testing. This Guideline has been endorsed by numerous other expert societies, including from India and South America.

The updated guidance is a significant change from previous recommendations because extensive randomised trial evidence has been gathered since the last guideline was produced. The guideline and evidence is freely available at https://www.endocrine.org/clinical-practice-guidelines/vitamin-d-for-prevention-of-disease Accessed January 2026).

Affected 'at risk' groups include for whom empiric treatment is now recommended include:

- persons with low sun exposure, including dark skinned persons from African or Indian subcontinents, as well as those with high covering for cultural, religious or lifestyle reasons
- persons age 75yr and over, especially frail elderly patients living indoors
- pregnancy and postpartum
- children ages 1-18yr

The Guideline also does not support follow up testing in individuals from the above groups on supplementation unless there is a clear reason.

It also does not advocate either routine testing or supplementation in healthy community-dwelling adults, citing a lack of rigorous evidence for benefit.
Empiric supplementation is recommended either as daily or monthly supplements in addition to usual food sources, e.g. conveniently a monthly dose of 1.25mg cholecalciferol. Vitamin D treatment is cheap, with the cost of testing exceeding several years of monthly supplements. The Guideline considered supplementation to be acceptable to both patients and health care professionals, and to have no negative effect on health equity.
Local endocrinologists agree with and endorse this overall approach.

Recommended levels – what does a low result mean?

The Guideline found that the evidence base to define vitamin D 'sufficiency' (≥50 nmol/L), 'insufficiency' (26-49nmol/L) and 'deficiency' (≤25 nmol/L) to be not adequately robust to endorse these thresholds and the Endocrine Society has withdrawn its support for them (McCartney, 2024).

The cutoff for low vitamin D stores is no longer well defined. While a level below 25 nmol/L suggests low body stores, the large majority of such patients have normal serum calcium and ALP, and rates of biochemical osteomalacia are very low unless deficiency is severe (McDonald, 2025). Extensive recent data summarising many trials also shows no clear evidence for an effect of vitamin D on major outcomes including overall mortality, fractures, CVD (including MI and stroke), and cancer (McCartney, 2024).

Notably, levels vary significantly across the seasons, being lower in winter (Bolland 2008). A level of 40 nmol/L in summer typically equates to about 25 nmol/L in winter, highlighting the influence of recent sun exposure and the limited reliability of one measurement to detect long-term inadequate stores.

Serum levels are also influenced by the level of vitamin D binding protein, independent of vitamin D status. Measured levels are significantly lower in nephrotic syndrome and fall temporarily by about 20-30% in inflammatory illness (a negative 'acute phase' effect). There is also racial variation in binding protein concentration, with lower levels of vitamin D binding protein in blacks (Powe 2013).

B. LOCAL TESTING TRENDS – MARKED INCREASES WITHOUT CLEAR CLINICAL BENEFIT

In 2012 restrictions on vitamin D testing were introduced in Auckland because of a 380% increase in test requests between 2000 and 2010. This was aimed at better targeting individuals who were more likely to be deficient. (Bolland 2012)

However, these changes were only partially successful, and over the last 5-6 years there has been a compounding increase in vitamin D requesting by over 30% annually, with a five-fold increase despite very little if any evidence for outcome benefit (figure 1).This rate of increase is unsustainable.

The proportion of patients with vitamin D levels below 25 nmol/L has remained about 10% overall, with 2/3 having results >50 nmol/L, suggesting very little impact of previous guidance intended to identify high risk patients (Bolland 2021).
As in 2012, the majority of the recent increase is disproportionately driven by a minority of requestors, where in some cases testing seems almost 'routine' in most patients. While the median number of requests in primary care was 6 per year, the top 25 requestors in primary care ordered about 30% of all tests. Although previous restrictions required specific reasons for testing, recently this has also often not been provided and in many cases no clinical reason other than 'high risk' has been stated as an indication.

Figure 1. Number of publicly funded 25OH vitamin D tests in Auckland since 2005.

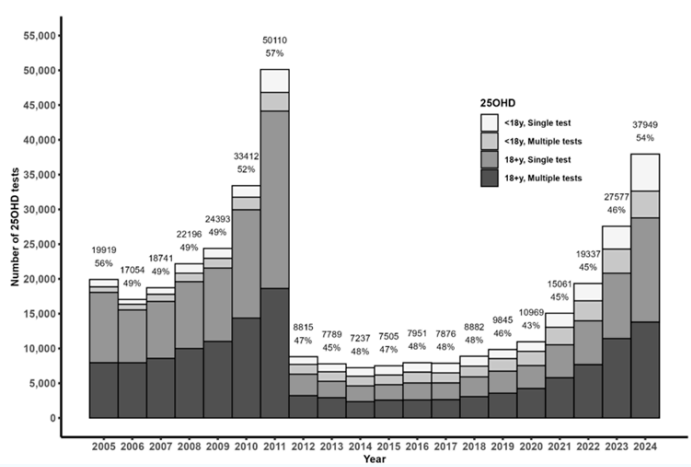


Figure 1: Number of 25OHD measurements by year and by age. In 2012 restrictions were introduced for adults. The number and percentage above the bars are individuals in each year with a single 25OHD measurement during the 20 years.

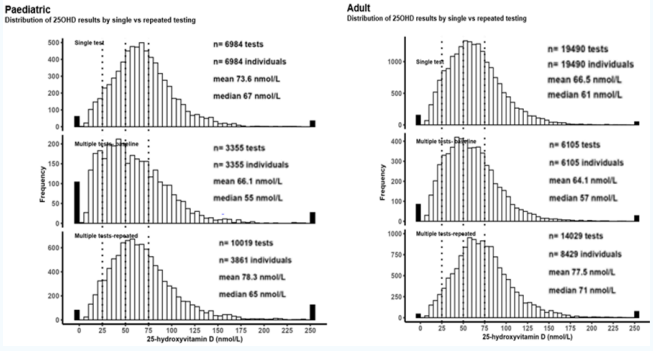
Testing is not cost-effective to identify risk of clinical complications without other evidence:

Overall, about 1/10 adults and 1/12 children have 25OHD ≤25 nmol/L. However, the number of patients showing other biochemical evidence of deficiency is very low when measured around the time of the 25OHD request. Only 1-2% have low serum calcium and only 5-7% have high ALP. If the appropriate goal of testing is to identify patients at risk of clinical complications of vitamin D deficiency, then very large numbers of vitamin D tests (>1000 tests in adults and 125 in children) would be needed to identify one patient with other evidence of vitamin D related abnormal biochemistry.

Repeat testing is high, also with very limited evidence of value

Detailed local audit over 20 years in Auckland/Northland (Bolland 2026) shows repeat testing of vitamin D is very common, accounting for about a third of all tests (almost 80% being performed within 2yr). There is very little difference in the first test between those who have one test and those with repeats (mean initial result for single test was 58nmol/L vs 56 nmol/L with repeat).

Figure 2. Distribution of initial and repeat vitamin D tests in adults and children (Auckland and Northland)



Repeat tests tend to be higher than baseline levels and only a small number (5-8% across different specialties) are ≤25 nmol/L. If the previous test was normal (≥50 nmol/L, and especially >75 nmol/L) the value of repeated testing in identifying deficiency is very low, with only 1.5% of requests showing a level ≤25nmol/L within 2yrs and only 13% less than 50nmol/L (figure 2).

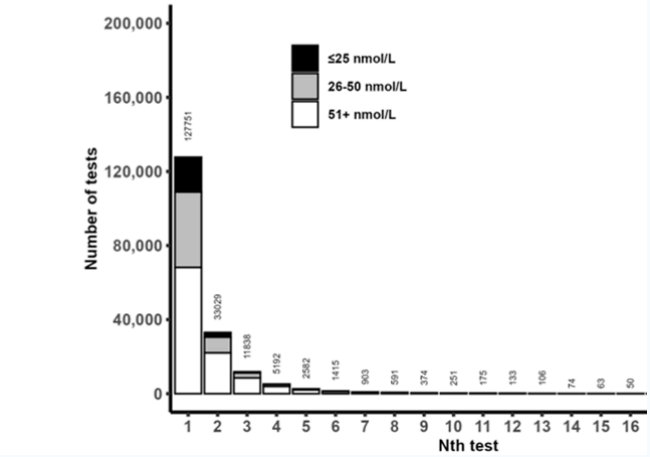
As shown in figure 3, low results are particularly uncommon when patients have ongoing repeat testing (3 or more repeated tests), even in patients with known malabsorption on long-term supplements (e.g. only 0.3% of bariatric surgery patients have results ≤25nmol/L if the last result was >50 within 2 years).

25OH Vitamin D Testing - A change in approach...*cont*

The top 25 requestors (less than 1% of GPs) order over 30% of all tests, and the top 5% order over 55%. Conversely over half of all GPs order no more than 2 tests per year (the median number is one). Some patients have at least annual repeat vitamin D tests over many years, and in a few cases much more often. The maximum number was 127 requests in one patient over 20 years. Overall, however, low results were not more common in these high frequency requestors.

This indicates that ongoing repeated testing when on supplements typically has very low clinical value unless there is a change in clinical status, or clear biochemical or radiological evidence to indicate ongoing deficiency.

Figure 3. Diminishing number of low results with increasing test frequency for a patient in primary care



A. POLICY CHANGE TO VITAMIN D REQUESTING

Vitamin D testing indications have been discussed with regional adult and paediatric endocrinologists, a number of other specialties, and primary care representatives. New recommendations have been agreed upon and authorised by the Auckland Regional Demand Management Group, Regional Integrated Clinical Governance Group, Primary Care Leaders, and Health Pathways.

Vitamin D requests will generate a 'popup' box in Awanui e-orders. Requests by other written or PMS forms may not be approved if one of these indications is not given. Patients can continue to self-request and pay for testing.

In general, it is expected that all cases needing funded 25OHD testing will be under, or referred for, specialist care. If serum calcium and phosphate are normal vitamin D testing is rarely necessary.

Appropriate indications for testing are:

Only a single request per form (no ongoing repeat requests)
No previous 25OH-vitamin D >50 nmol/L in the last two years
→ Repeated testing during or after treatment is rarely indicated. In particular testing within 2 years is not indicated if the previous vitamin D result was >50 nmol/L, unless there is high suspicion of non-compliance or poor response. Specialist endorsement is required in this situation.

A. FIRST ASSESSMENT:

- Low serum adjusted calcium (unexplained)
- Raised serum ALP of likely bone origin (unexplained)
- Other reason. Secondary care specialist request or endorsement is required

→ Reasons for endocrinologist or paediatrician approval would most often include (not exhaustive):

- suspected toxicity (rare, typically high calcium, low normal/low PTH, with history of high doses)
- other unusual bone disorders such as atypical osteoporosis
- high risk follow-up with poor biochemical or X ray response to treatment (usually only in children)
- note that osteoporosis by Dexa scan or post-menopausal fracture is not considered an indication

B. TREATMENT RESPONSE TESTING:

- Established cause of malabsorption syndrome or malnutrition
- Clear reason to suspect ongoing deficiency (persisting low Ca, high ALP, X ray evidence)
- Clear change in clinical status
- Secondary care specialist testing or endorsement required

→ Routine retesting is rarely indicated. It should be after >3mo treatment with last result less than 50 nmol/L. If the previous follow up test shows adequate replacement, further testing is NOT indicated unless there is significant clinical change.

C. IN OTHER SITUATIONS:

- Patient to pay
- Chemical Pathologist/endocrinologist preapproval

25OH Vitamin D Testing - A change in approach...*cont*

REFERENCES:

Demay MB, Pittas AG, Bikle, DD, et al. Vitamin D for the prevention of disease: An Endocrine Society Clinical Practice Guideline. J. Clin. Endocrinol. Metab. 2024; 109(8): 1907-47. https://doi.org/10.1210/clinem/dgae290 (freely available).

Shah VP, Nayfeh T, Alsawaf Y, et al. A systematic review supporting the Endocrine Society Clinical Practice Guidelines n vitamin D. J. Clin. Endocrinol. Metab. 2024; 109(8): 1961-74. https://doi.org/10.1210/clinem/dgae312 (freely available).

McCartney CR, McDonnell ME, Corrigan MD, et al. Vitamin D insufficiency and epistemic humility: And Endocrine Society Guideline communication. J. Clin. Endocrinol. Metab. 2024; 109(8): 1948-54. https://doi.org/10.1210/clinem/dgae322 (freely available)

McDonald AD, Bolland MJ, Balfour A, et al. Biochemical osteomalacia in adults undergoing vitamin D testing in the North-East of Scotland. Ann. Clin. Biochem. 2025; 62(4): 303-11.

Bolland MJ, Chiu WW, Davidson JS, et al. The effects of seasonal variation of 25-hydroxyvitamin D on diagnosis of vitamin D insufficiency. N. Z. Med. J. 2008; 121(1286): 63-74.

Powe CE, Evans MK, Wenger J, et al. Vitamin D-binding protein and vitamin D status of black Americans and white Americans. N. Engl. J. Med. 369(21): 1991-2000.

Bolland MJ, Grey A, Davidson JS, et al. Should measurement of vitamin D and treatment of vitamin D insufficiency be routine in New Zealand? N.Z.Med.J. 2012; 125(1349): 83-91.

Grey A, Bolland MJ, Davidson J. Vitamin D testing. Lancet 2012; 379 (9827): 1699

Bolland MJ, Avenell A, Grey A. vitamin D deficiency, supplementation and testing: have we got it right in New Zealand? N.Z.Med.J. 2021: 134(1541): 86-95

Bolland MJ, Kyle CV, Grey A. 2026 Repeated measurements of vitamin D: common and very unlikely to indicate deficiency. Clin. Endocrinol (submitted).

Dr Cam Kyle
095747399
Cam.Kyle@awanuilabs.co.nz

Repatriation of Immunology Testing Services

As we kick start 2026, we are pleased to share an important service update.
Awanui Labs Auckland has now completed the repatriation of Immunology testing services. Autoimmune disease testing has been performed locally on the BioFlash analyser since 25 November 2025, with serology testing more recently to the DiaSorin LIAISON platform from 19 January with an expanded test menu. These analysers were carefully selected, validated, and implemented through a collaborative effort across the wider Awanui network, ensuring the service is robust and appropriate for Auckland testing volumes.

What this means for you:

- Local testing: a wider range of Immunology testing performed in Auckland, closer to patients and referrers
- Improved turnaround times: reduced transit time supports timely result reporting
- Continuity of quality: testing is delivered on fully validated platforms, meeting clinical and quality standards
- Service stability: the repatriation strengthens long-term sustainability of immunology services in the Northern region

We would like to sincerely thank you for your patience and understanding throughout last year, when Immunology testing was supported by our Wellington laboratory colleagues.
Awanui Lab Auckland is now fully operational for immunology testing and remains committed to delivering reliable, quality diagnostic services to support patient care across the Northern region.

Guidance on Allergy Testing: Choosing Wisely for Better Outcomes

Awanui Labs is updating its approach and guidance for referrers on allergy testing to promote clinically appropriate use, reduce harm from over testing, and support equitable access.

The focus is on using tests only where results will change management, avoid unnecessary restriction of well tolerated foods, and methods to fit a modern, automated laboratory environment.

New Zealand has one of the highest burdens for allergic disease in the world with over 40 percent of the population being classified as atopic, which is defined as having positive specific IgE, or skin prick testing to common environmental allergens.

Given how common atopic disease is in this country, it is important clinicians maintain a good working knowledge of the assessment of asthma, eczema and allergic rhinitis and where allergy testing is helpful in the diagnosis and management of these conditions.

In this guidance, Awanui Labs Chief Medical Director Richard Steele discusses different principles for ordering allergy tests within the Awanui laboratory network to support the optimal use of allergy testing saving time, cost, and delivering the right outcomes for your patients.

These key principles are outlined below to guide safe, and effective practice.

Principle 1: Test Only in the Right Context

Allergy testing is a finite resource and should be reserved for situations where there is a clear clinical indication and the result will guide management.

- Aeroallergens: Testing should be limited to patients with persistent, recurrent, severe rhinitis or asthma not controlled on standard therapy and only where results will influence treatment decisions. It is not indicated for eczema in primary care and is only rarely helpful in specialist practice unless there is significant allergic rhinitis or asthma present.
- Food allergens: Testing is appropriate when there is a history suggestive of an IgE mediated immediate reaction and the patient is currently avoiding the food. Skin prick and specific IgE are both valid modalities, however, oral food challenge remains the gold standard when the diagnosis is uncertain.
- Indiscriminate food testing: Broad, non-targeted food panels frequently detect sensitisation in patients who are clinically tolerant, driving unnecessary food avoidance and nutritional risk, especially in children. One study of 274 patients undergoing indiscriminate serum food panels generated about US$80,000 in excess health care costs, with many individuals sensitised on testing but ultimately not diagnosed with food allergy after specialist evaluation.

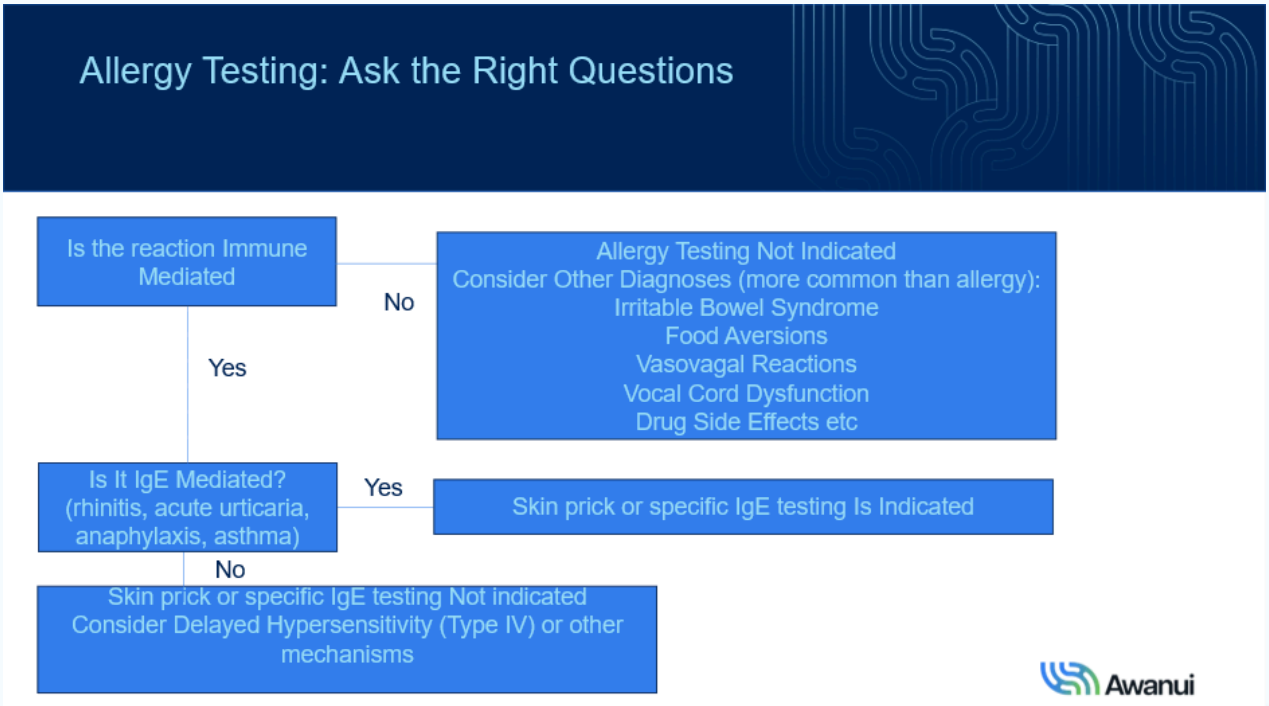


Figure 1 (Indications for Allergy Testing) outlines when IgE mediated allergy testing is appropriate and emphasises that testing outside these indications can lead to harm.

- Maintaining regular oral exposure to tolerated foods is critical, as stopping these foods on the basis of a positive test alone can increase the risk of developing true IgE mediated food allergy, including anaphylaxis. Testing is not indicated for non IgE mediated conditions such as irritable bowel syndrome, and for eosinophilic oesophagitis or oral allergy syndrome, broad food testing is unhelpful. In oral allergy syndrome, birch pollen testing alone is recommended to support the diagnosis.

Principle 2: Specific IgE or skin prick testing can be used but not both

For IgE mediated allergy, clinicians should choose either serum specific IgE or skin prick testing for a given allergen but not order both, as using both does not improve diagnostic accuracy and adds unnecessary cost and complexity.

Both modalities have broadly similar diagnostic performance and should be selected according to patient factors and system constraints. Specific IgE is often preferable when there are equity barriers to attending skin prick testing appointments, when patients cannot stop antihistamines, in dermographism, or when the relevant allergen (for example certain tree nuts or molluscs) is not available as a skin prick. Skin prick testing, while offered through Awanui, is inherently manual, more prone to technical and transcription errors, and carries a small risk of systemic reactions or vasovagal events requiring immediate attention.

Specific IgE testing is well suited to the modern laboratory: it is fully automated, electronically ordered and resulted, and removes many of the manual steps that introduce error. From clinical, operational and financial perspectives, Awanui is therefore shifting toward specific IgE as the preferred modality where this makes sense, with the balance between methods to be reviewed over the next six months

Principle 3: Allergy test ordering in primary care should be limited to the common clinically relevant allergens encountered

In primary care, both the range and number of allergens tested should be limited, and Awanui will implement this policy in 2026.

Professional bodies such as the American Academy of Allergy, Asthma and Immunology recommend restricting broad allergen panels to allergy specialists or general practitioners with appropriate extra training.

- Recommended aeroallergens for primary care: House dust mite, grass mix, cat, dog, birch, plantain and a mould mix, with a maximum of 7 aeroallergens per patient.
- Recommended food allergens for primary care: Peanut, wheat, milk, egg, soy, selected tree nuts (almond, Brazil nut, cashew, hazelnut, macadamia, pecan, pistachio, walnut) and common seafoods (e.g. codfish, shrimp, mussel, lobster, oyster, tuna, salmon, crab, scallop), with a maximum of 3 food allergens per patient.

Access to a broader range of tests should be limited to clinicians with demonstrated allergy expertise (such as clinical immunologists, immunopathologists, allergists, paediatricians, or GPs with extended allergy roles), use within agreed Health Pathways, or GPs who have completed approved allergy training modules. This approach is designed to reduce over diagnosis, minimise harm and unnecessary resource use, and direct complex cases to appropriately trained clinicians.

For further information, please see the table below, the Awanui Test Guide or discuss with an Awanui Labs Immunopathologist.

Guidance on Allergy Testing: Choosing Wisely for Better Outcomes...*cont*

For Aeroallergens, allergy testing should be reserved only for those with persistent, recurrent and severe rhinitis or asthma symptoms not controlled with standard therapy AND the results will guide management
Specific IgE or skin prick testing can be used to test for the same allergen but do not order both
Allergy test ordering in primary care should be limited to the common clinically relevant allergens encountered
Positive tests without allergy (sensitisation) occurs 5 times more commonly than true allergy
The positive and negative predictive value for a given wheal size or specific IgE antibody level will vary for each individual allergen and for most allergens that is not known.
Larger wheal size or higher the specific IgE level the more likely a person is allergic to that particular allergen BUT does not predict the reaction severity
There is no definite cut off for either wheal size (<3mm) or specific IgE level (<0.35kUA/l) they are arbitrary True allergy can occur at levels lower than the cut-off
Skin prick testing in children, a small wheal (sometimes <3mm) with a very large flares\ is commonly seen in true allergy
For foods, a specific IgE level less than 0.1kAU/l or a negative skin prick test has a high negative predictive value that the patient is not allergic BUT it is only a test and specialist advice should always be sought when re-introducing the food in question where there is a history of a previous IgE mediated reaction
For foods, allergy testing should only be performed in those with a history of an acute IgE mediated reaction who is currently avoiding the food in question
If a patient has a positive allergy test to a food they are currently tolerating, they should be encouraged to continue to eat that food on a regular basis. Cessation may lead to true IgE-mediated allergy including anaphylaxis
Multiple negative results (usually house dust mite, cat, dog, birch, grasses, plantain) with no positive results it is very unlikely that atopy is a factor contributing your patient's symptoms e.g. allergic versus non-allergic rhinitis or in asthma
For pollens, all the relevant allergens (e.g. grasses, plantain, birch) are introduced species that produce airborne pollens. No native plant (pollinated by insect or bird spread) has ever been demonstrated to cause allergy

Dr Richard Steele
095747399
Richard.Steele@awanuigroup.co.nz

Northland Key Contacts (09) 438 4243

Results		Press '1'	24 hours/7 days per week
Test Bookings	Book online through www.awanuilabs.co.nz	Press '2'	
Home Visits	Email nth.homevisits@awanuilabs.co.nz If the home visit cannot be booked for the date requested Home Visits staff will contact the referrer to arrange an alternative date. Phone enquiries to (09)438 4243	Press '3'	Mon-Fri: 8:00am to 3:00pm
Stores	nth.stores@awanuilabs.co.nz	Press '4'	Mon-Fri 8:00am to 5:00pm
Other Enquiries	nth.admin@awanuilabs.co.nz	Press '5' or Hold the line	Mon-Fri 8:00am to 6:00pm
E-orders Helpline	Email: helpdesk@eorder.co.nz	0508 37 37 83	

Auckland Key Contacts (09) 574 7399

Results		Press '1'	24 hours/7 days per week
Courier		Press '2'	24 hours/7 days per week
Home Visits	Email to auk.home.visits@awanuilabs.co.nz (preferred) If the home visit cannot be booked for the date requested Home Visits staff will contact the referrer to arrange an alternative date.	Press '3'	Mon-Fri: 8:00am to 6:00pm Sat: 8:00am to 12:00pm
Special test bookings	Book online anytime at https://awanui-bookings.labapps.nz/booking-client/#/login/	Press '4'	Mon-Fri 8:00am to 6:00pm
Other Enquiries		Hold the line	Mon-Fri 7:00am to 11pm Sat-Sun 8:00am to 7:00pm
Add on tests	Requests for add on tests can be emailed to: call.centre@awanuilabs.co.nz		Note: some add on tests may require pathologists' approval.
Consumables orders	To enquire about consumables orders	Press '2'	Mon–Fri 07:00am to 3:30pm
Dedicated line for practitioners to access all results (24/7)		(09) 574 7398	

Pathologists:

Medical Director: Dr Lesley Overend

ph (09) 574 7398

Lesley.Overend@awanuilabs.co.nz

Chemical Pathologists	Haematologists	Microbiologists
Dr Charles Ng Charles.Ng@awanuilabs.co.nz	Dr Lesley Overend Lesley.Overend@awanuilabs.co.nz	Dr Ranmini Kularatne Ranmini.Kularatne@awanuilabs.co.nz
Dr Melissa Yssel Melissa.Yssel@awanuilabs.co.nz	Dr Fransisca De Silva Fransisca.Desilva@awanuilabs.co.nz	Dr Matt Blakiston Matthew.Blakiston@awanuilabs.co.nz
Dr Cam Kyle Cam.Kyle@awanuilabs.co.nz	Dr Kim Nash Kim.Nash@awanuilabs.co.nz	Dr Aakash Chhibber Aakash.Chhibber@awanuilabs.co.nz

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Anatomic Pathology Service
Mount Wellington

The contact number for Anatomic Pathology Mt Wellington is:
Phone (09) 302 0516

Awanui Labs