17-Hydroxyprogesterone Test

17-HYDROXYPROGESTERONE TEST

Patient Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____

Reason for Test:

Additional Notes:

Ordering Physician: _____ Contact Information: _____

Date of the Test: _____ dd / mm / yyyy Laboratory Name: _____

Laboratory Address: _____

Laboratory Contact Information: _____ Specimen Type (Blood: Serum/Plasma, Saliva): _____

Collection Date and Time: _____

RESULTS

Patient's Results: _____ Reference Range: _____

INTERPRETATION

Interpretation

◯ Within the reference range ◯ Above the reference range ◯ Below the reference range

Clinical Implications:

Additional Notes:

Reporting Physician: _____ Date: _____ dd / mm / yyyy