Blood Test Lab Request Form

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RECIPIENT LAB INFORMATION

Laboratory name: _____ Laboratory location: _____

Requester information

Physician name: _____

Medical practice address

Employee ID: _____ Phone: _____

Email: _____

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

What is your gender?

◯ Male ◯ Female

Sex: _____ Age: _____

Street Address: _____ City: _____

Postcode: _____ Attending physician: _____

Clinical details/medications / antibiotics

SAMPLE DETAILS

Sample ID: _____ Collected by: _____

Employee ID: _____ Collection date: _____ dd / mm / yyyy

Collection time: _____

BLOOD TESTS REQUESTED

Biochemistry

- ☐ Renal profile
- ☐ Calcium
- ☐ Urea
- ☐ Troponin - T
- ☐ Glucose
- ☐ TSH
- ☐ Folate
- ☐ Ferritin
- ☐ Liver profile
- ☐ Phosphate
- ☐ Magnesium
- ☐ CRP
- ☐ Lipase
- ☐ FT4
- ☐ Vitamin B12

Hematology

- [ ] Complete blood count (CBC)

Immuno/Virology

- [ ] Electrophoresis
- [ ] Immunoglobulins
- [ ] Coeliac serology
- [ ] ANA
- [ ] HIV

Coagulation

- [ ] Coagulation screen
- [ ] Warfarin monitoring (INR)
- [ ] Heparin monitoring (APTT)

Blood gasses

- [ ] Arterial
- [ ] Venous
- [ ] FiO2
- [ ] Temp
- [ ] Ferritin

Other tests

AUTHORIZER INFORMATION

Request authorized by: _____ **Date:** _____ dd / mm / yyyy

_____

Signature

LABORATORY USE ONLY

Date received: _____ dd / mm / yyyy **Received by:** _____

Request accepted

◯ Yes ◯ No

If not, please specify reason

Tests performed

Date: _____ dd / mm / yyyy **Results delivery date:** _____ dd / mm / yyyy