

A1C Test

Patient Name:	
Date of Birth (MM/DD/YYYY):	
Gender:	
Address:	
Phone Number:	
Appointment Date (MM/DD/YYYY):	Appointment Time:
Reason for A1C Test:	

<p>Patient Consent:</p> <p>I, the undersigned, hereby consent to the A1C test as recommended by my healthcare provider. I understand the purpose of this test and agree to follow the provided instructions for sample collection and testing.</p> <p>Patient Signature:</p> <p>Date: ____/____/____ (MM/DD/YYYY)</p>

<p>Provider's Recommendation:</p> <p><input type="checkbox"/> No fasting required.</p> <p><input type="checkbox"/> Fasting required: _____ hours.</p>
Certified Laboratory Name:
Laboratory Address:
Contact Information:
Medications:
Lifestyle Modifications:
Recommendations:

Follow-up Appointment Date: _____/_____/_____ (MM/DD/YYYY)

Provider's Signature:

Date: _____/_____/_____ (MM/DD/YYYY)