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:	

Patient Consent:

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.

Patient Signature:

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

Provider's Recommendation:

- ☐ No fasting required.
- ☐ Fasting required: _____ hours.

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)