Blood Test Lab Request Form

Recipient lab information		
Laboratory name:	Laboratory location:	
Requester information		
Physician name:	Employee ID:	
Phone:	Email:	
Medical practice address:		
Patient information		
Name:	Age:	
Gender:	Sex:	
Date of birth:		
Address:		
Attending physician:		
Clinical details/medications/antibiotics:		
Sample details		
Sample ID:	Collection date:	
Collected by:	Collection time:	
Employee ID:		

Hematology:	Biochemistry:
Complete blood count (CBC)	Renal profile
Immuno/Virology:	Liver profile
Electrophoresis	Calcium
Immunoglobulins	Phosphate
Coeliac serology	Urea
ANA	Magnesium
HIV	Troponin - T
Coagulation:	CRP
Coagulation screen	Glucose
Warfarin monitoring (INR)	Lipase
Heparin monitoring (APTT)	TSH
Blood gasses:	FT4
Arterial	Folate
Venous	Vitamin B12
FiO ₂ :	Ferritin
Temp:	
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Other tests:	
Other tests:	

Laboratory use only		
Date received:		
Received by:		
Request accepted: Yes No		
If not, please specify reason:		
Tests performed:	Date:	
Results delivery date:		