Glomerular Filtration Rate (GFR) Test Request Form

Patient Information

- Patient's Full Name:
- Date of Birth:
- Gender:
- Medical Record Number (if applicable):

Clinical Information

- Referring Physician/Healthcare Provider:
- Date of Request:
- Reason for GFR Test (Check applicable):

☐ Diagnosis and Monitoring of Chronic Kidney Disease (CKD)

☐ Medication Dosage Adjustment

☐ Monitoring Acute Kidney Injury (AKI)

☐ Hypertension Management

☐ Diabetes Management

☐ Kidney Transplant Evaluation

☐ Research or Clinical Trial

Test Details

- Type of Sample (Check applicable)

☐ Blood

☐ 24-Hour Urine

- Test Location (Specify if other than your facility):
- Preferred Date and Time of Test:

Clinical Notes

Additional information or clinical notes regarding the patient's kidney health or other relevant details.

Provider's Contact Information

- Name of Healthcare Facility/Clinic:
- Provider's Name:
- Provider's Contact Phone:
- Provider's Contact Email:

Patient Consent and Acknowledgment

I, the undersigned patient or authorized representative, acknowledge and consent to the Glomerular Filtration Rate (GFR) test as requested by my healthcare provider. I understand the purpose and potential implications of this test.

Patient's Signature:

Date:

Provider's Signature:

Date: ______________