

# 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: \_\_\_\_\_