# Helicobacter Pylori Test Request Form

**Patient Information**

Full Name: ___________________________Date of Birth:____________________

Gender:________Phone Number:________________Email:________________________

Address:__________________________________________________________

City:____________State:_______________Zip Code:___________________

Email:____________________________

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**Referring Physician Information (if applicable)**

Physician's Name:_________________________________

Clinic/Hospital Name:_______________________________

Phone Number:_______________________Email:___________________________

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**Test Type (Please select one)**

- ☐ Stool Test
- ☐ Blood Test

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**Specimen Collection Instructions**
**Stool Test**

- Please collect a stool sample using the provided collection container.
- Ensure that the container is tightly sealed after collection.
- Label the container with your full name, date, and any unique identifiers provided.
- Follow any fasting or dietary instructions provided.

**Blood Test**

- Visit our clinic or a designated laboratory for blood collection. No fasting is usually required.
- Ensure that your full name and date of birth are correctly noted on the blood vial.
- If there are any specific preparation instructions, our staff will guide you.

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### Specimen Submission

- Return the labeled container to our clinic or a designated collection site as instructed for stool tests.
- For blood tests, visit our clinic or the designated laboratory for blood collection.

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### Patient Consent

I, the undersigned, consent to undergo the Helicobacter pylori test as indicated above. I understand the instructions provided and will follow them accordingly. I authorize the release of test results to my healthcare provider for further evaluation and treatment if necessary.

Patient Signature:____________________Date:_______________________

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### For Medical Professional Use Only

Test Ordered By:_________________________Date:__________________

Clinic/Lab ID:____________________________

Lab Technician:__________________________

### Medical Practice Contact Information

Phone:______________________Email:__________________________

Address:___________________________________________________

Please return this form with the specimen container to our clinic or the designated collection site. Thank you for choosing our practice for your healthcare needs.