Tumor Marker Blood Test Form

Patient Information

Full Name:

Date of Birth:

Gender:

Patient ID:

Contact Number:

Address:

Referring Physician Information

Name:

Specialty:

Contact Number:

Email Address:

Medical History

Previous Diagnoses

Current Medications

Known Allergies

Reason for Test

- ☐ Routine Screening
- ☐ Monitoring Treatment Response
- ☐ Checking for Recurrence
- ☐ Other: ___________________________________

Tumor Markers to be Tested

- ☐ Alpha-fetoprotein (AFP)
- ☐ CA 19-9
- ☐ CA 125
- ☐ Carcinoembryonic antigen (CEA)
- ☐ Human chorionic gonadotropin (HCG)
- ☐ Prostate-specific antigen (PSA)
- ☐ Other: ___________________________________

Sample Collection

Date of Collection:

Time:

Collected by (Healthcare Professional's Name):

Laboratory Results

Tumor Marker	Value	Reference Range
Alpha-fetoprotein (AFP)		
CA 19-9		
CA 125		
Carcinoembryonic antigen (CEA)		
Human chorionic gonadotropin (HCG)		
Prostate-specific antigen (PSA)		

Interpretation

Recommendations

- ☐ Further diagnostic tests
- ☐ Consultation with an oncologist
- ☐ Monitoring
- ☐ Other: ________________________________

Physician's Notes

Physician's Signature: ____________________________

Date: _______ / _______ / ______