UIBC Blood Test

Patient Information	
Name:	Date of Birth:
Gender: Male Female Other:	
Address:	
Phone:	Email:
Patient History	
Clinical Indication:	
Symptoms:	
Medical History:	
Medications:	
Allergies:	
Test Details	
Test Name:	
Reason for Test:	
Additional Tests Ordered:	
Special Instructions:	
Fasting Required: ☐ Yes No (12 hours)	

Sample Collection	
Location:	
Date and Time:	
Laboratory Information	
Preferred Laboratory:	
Address:	
Contact:	Fax:
Results and Reporting	
Results to be Reported to:	
Specify Preferred Method: ☐ Phone Email Fax Mail	
Expected Result Delivery Time:	
Physician's Information	
Physician's Name:	Medical License Number:
Contact Information:	
Patient Consent	
I, the undersigned, consent to the Unbound Iron-Binding Capacity (UIBC) Blood Test and any additional tests as indicated. I understand the purpose, potential risks, and benefits of the test, and I authorize the release of the test results to the specified parties.	
Patient's Signature:	