AST Test

Patient Information

Full Name: ________________________________Date of Birth: ___________________

Gender: _______ Medical Record Number: ____________________________________

Clinical History

Reason for AST Test:

Indicate the reason for conducting the AST test, e.g., symptoms, routine check-up, follow-up, etc.

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Clinical Symptoms

Document any relevant symptoms the patient is experiencing.

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Test Procedure

Date of Test:

Time of Test:

Sample Collection

Specify the method used for blood sample collection, e.g., venipuncture

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Sample Source

Specify the source of the blood sample, e.g., arm vein

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Specimen Handling

Detail how the specimen was handled, including any special instructions or precautions.

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Laboratory Results

AST Level

Record the patient's AST level in U/L or IU/L

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Reference Range

Include the laboratory's reference range for AST

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Interpretation

Interpret the results, indicating whether the AST levels are within the normal range or elevated.

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Clinical Assessment

Diagnosis

Record any diagnosis based on the AST test results and other clinical information.

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Treatment Plan

Outline the recommended treatment plan, if applicable.

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Follow-up

Date for Follow-up:

Additional Tests

Indicate if further tests or monitoring are required.

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Provider Information

Name of Healthcare Provider:

Medical License Number:

Contact Information: (555) 123-4567; dr.smith@example.com

Patient Consent

I consent to the AST test and understand its purpose and potential outcomes. I have had the opportunity to ask questions and have received satisfactory answers.

Patient's Signature:________________________________Date:____________________