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.

-

Clinical Symptoms

Document any relevant symptoms the patient is experiencing.

-

Test Procedure

Date of Test:

Time of Test:

Sample Collection

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

-

Sample Source

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

-

Specimen Handling

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

-

Laboratory Results

AST Level

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

-

Reference Range

Include the laboratory's reference range for AST

-

Interpretation

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

-

Clinical Assessment

Diagnosis

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

-

Treatment Plan

Outline the recommended treatment plan, if applicable.

-

Follow-up

Date for Follow-up:

Additional Tests

Indicate if further tests or monitoring are required.

-

Provider Information

Name of Healthcare Provider:

Medical License Number:

Contact Information:

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:_____