BILIRUBIN BLOOD TEST REQUISITION FORM

PATIENT INFORMATION

Name: John Doe Date of Birth: 05/15/1975

Gender: Male Email: johndoe@email.com Phone Number: 123456789

Address: 123 Main Street, Anytown, USA

Medical Record Number: 1234567

HEALTHCARE PROVIDER INFORMATION

Provider Name: Dr. Jane Smith

Medical License Number: MD123456

Clinic/Hospital Name: Smith Medical Clinic

Phone Number: (555) 123-4567 Fax Number: (555) 987-6543

Test Specifications:

Test Requested: Bilirubin Blood Test

Clinical Indication (Reason for Test):

Patient presents with jaundice and fatigue, indicating potential liver dysfunction. Bilirubin test required for diagnostic evaluation.

Additional Notes/Instructions:

None.

Patient Consent

I, the undersigned patient or legal guardian, hereby consent to perform the Bilirubin Blood Test as ordered by my healthcare provider. I understand the nature of the test, its purpose, and the potential risks and benefits.

Patient Signature: John Doe **Date:** 09/20/2023

For Office Use Only

Date and Time of Collection: 09/21/2023, 08:30 AM
Phlebotomist/Collector Name: Sarah Johnson
Laboratory Processing Date: 09/21/2023
Results:
Total Bilirubin 2.3 mg/dL |
Direct Bilirubin 0.8 mg/dL | Indirect Bilirubin 1.5 mg/dL

Provider Signature: Dr. Jane Smith **Date:** 09/21/2023