BILIRUBIN BLOOD TEST REQUISITION FORM

PATIENT INFORMATION

Name: _____Date of Birth: _____

Gender: _____ Email: _____ Phone Number:_____

Address: _____

Medical Record Number: _____

HEALTHCARE PROVIDER INFORMATION

Provider Name: _____

Medical License Number: _____

Clinic/Hospital Name: _____

Phone Number: _____ Fax Number: _____

Test Specifications:

Test Requested: Bilirubin Blood Test

Clinical Indication (Reason for Test):

Additional Notes/Instructions:

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:_____ **Date:**_____

For Office Use Only
Date and Time of Collection:
Phlebotomist/Collector Name:
Laboratory Processing Date:
Results:
Total Bilirubin _____ mg/dL |
Direct Bilirubin _____ mg/dL | Indirect Bilirubin _____ mg/dL

Provider Signature:_____**Date:**_____