

Blood Test Lab Request Form

Recipient lab information	
Laboratory name:	Laboratory location:
Requester information	
Physician name:	Employee ID:
Phone:	Email:
Medical practice address:	
Patient information	
Name:	Age:
Gender:	Sex:
Date of birth:	
Address:	
Attending physician:	
Clinical details/medications/antibiotics	
Sample details	
Sample ID:	Collection date:
Collected by:	Collection time:
Employee ID:	

Blood tests requested	
Hematology	Biochemistry
Complete blood count (CBC)	Renal profile
Immuno/Virology	Liver profile
Electrophoresis	Calcium
Immunoglobulins	Phosphate
Coeliac serology	Urea
ANA	Magnesium
HIV	Troponin - T
Coagulation	CRP
Coagulation screen	Glucose
Warfarin monitoring (INR)	Lipase
Heparin monitoring (APTT)	TSH
Blood gasses	FT4
Arterial	Folate
Venous	Vitamin B12
FiO ₂ :	Ferritin
Temp:	
Other tests:	
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Authorizer Information	
Request authorized by:	
Signature:	Date:

Laboratory use only

Date received:

Received by:

Request accepted: Yes No

If not, please specify reason:

Tests performed:

Date:

Results delivery date: