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:	
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:	