Celiac Disease Test Request Form

Patient Information:

Name: John Doe Date of Test: October 5, 2023

Date of Birth: 05/15/1980 Gender: Male Contact Information: johndoe@email.com | (555) 123-4567

Clinical Information:

- **Presenting Symptoms/Reason for Testing:**
  John presents with chronic diarrhea, abdominal pain, and unexplained weight loss over the past six months.

- **Family History of Celiac Disease:**
  - [x] Yes
  - [ ] No

- **History of Autoimmune Conditions:**
  - [ ] Yes
  - [x] No

Test Selection

Please select the appropriate tests:

- [x] Anti-tissue transglutaminase (tTG) antibodies
- [ ] Anti-endomysial antibodies (EMA)
- [x] Anti-deamidated gliadin peptides (DGP) antibodies
- [ ] Total IgA levels
- [ ] Small Intestine Biopsy (if necessary)

Special Instructions

- [ ] The patient should continue with a gluten-containing diet until testing is complete.
- [ ] Fasting is not required for this test.
- [x] Schedule a follow-up appointment to discuss the results.

Provider Information

- **Referring Physician:** Dr. Sarah Smith
- **Contact Information:** drsmith@emailclinic.com | (555) 987-6543

Lab Information

- **Laboratory Name:** ABC Medical Laboratory
- **Date of Sample Collection:** 09/20/2023
- **Specimen Type:**
  - ☑ Blood
  - ☐ Tissue

Patient Consent

I hereby consent to undergo the Celiac Disease Test as recommended by my healthcare provider. I understand the purpose and potential implications of this test.

Patient Signature: John Doe _____ **Date:** October 5, 2023 ___