

# Celiac Disease Test Request Form

Patient Information:

Name: \_\_\_\_\_ Date of Test: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Contact Information: \_\_\_\_\_

## Clinical Information:

- **Presenting Symptoms/Reason for Testing:**

- **Family History of Celiac Disease:**

Yes

No

- **History of Autoimmune Conditions:**

Yes

No

## Test Selection

Please select the appropriate tests:

- Anti-tissue transglutaminase (tTG) antibodies
- Anti-endomysial antibodies (EMA)
- 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.
- Schedule a follow-up appointment to discuss the results.

## Provider Information

- **Referring Physician:**
- **Contact Information:**

**Lab Information**

- **Laboratory Name:**
- **Date of Sample Collection:**
- **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:** \_\_\_\_\_ **Date:** \_\_\_\_\_