Chloride Blood Test Request Form

Patient Information

Name:

Date of Birth:

Gender:

Address:

Phone Number:

Email Address:

Physician Information

Name:

Medical License Number:

Contact Information:

Clinical Details

Reason for Test

Medical History

Specimen Collection

Date of Collection:

Time of Collection:

Fasting Required:

Other Instructions:

Test Request

Test Ordered:

Additional Tests:

Patient Consent

I hereby consent to the Chloride Blood Test and any additional tests deemed necessary by my healthcare provider. I understand the purpose and potential risks.

Patient's Signature:

Date:

Laboratory Information

Laboratory Name:

Laboratory Address:

Contact Information:

Submission:

Submit to Laboratory:

Copy Kept in Patient Records: