CO2 Blood Test

Patient Information			
Patient's Full Name:			
Date of Birth:			
Age:			
Gender:	Male	Female	Other:
Medical Record Number:			
Attending Physician's Full Name:			

Patient's Medical History

Symptoms

- [ ] Weakness
- [ ] Fatigue
- [ ] Nausea
- [ ] Vomiting
- [ ] Difficulty Breathing
- [ ] Confusion
- [ ] Disorientation
- [ ] Headaches
- [ ] Seizures
- [ ] Hyperventilation
- [ ] Rapid Heartbeats
- [ ] Lightheadedness

Other Symptoms:

CO2 Blood Test Results

CO2 Levels: mmol/l

- [ ] Normal
- [ ] High Amount of CO2
- [ ] Low Amount of CO2

Comments
Your test results will be kept confidential.

Signature
Signed by:
Date: