Cold Agglutinin Test Request Form

Patient Information:

Patient Name:_____Date of Birth:_____

Medical Record Number:_____Date of Test:_____

Healthcare Practitioner: _____

Clinical Details:

- **Referring Physician:**
- **Date of Referral:**
- **Reason for Testing:**

Clinical History:

- **Presenting Symptoms:**

- **Medical History:**

- **Medications:**
- **Past Diagnoses:**

Specimen Collection:

- **Collection Date:**
- **Time of Collection:**
- **Collection Site:**

Laboratory Instructions:

Special Considerations:

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Provider's Name and Signature:

- **Name:**
- **Signature:**
- **Date:**

Please attach any relevant medical records or additional information to assist in the interpretation of the Cold Agglutinin Test results. Ensure the patient is informed about the purpose and implications of the test.

Thank you for your cooperation in providing essential diagnostic information for our patient's care.