

# Fructosamine Test Request Form

## Patient Information

- Patient Name:
- Date of Birth:
- Medical Record Number:
- Gender:

## Contact Information

- Address:
- Phone Number:
- Email Address:

## Ordering Physician Information

- Physician Name:
- Clinic/Hospital Name:
- Contact Number:
- Fax Number:

## Clinical Details

- Reason for Fructosamine Test:
- Diagnosis or Medical Condition:
- Medications and Dosages:
- Other Relevant Information:

## Sample Collection Instructions

- Laboratory or Collection Center Location:
- Preferred Date and Time for Sample Collection:
- Fasting Requirements (if applicable):

**Patient Consent**

I, the undersigned, consent to the collection and analysis of my blood sample for the Fructosamine Test. I understand the purpose of this test and the potential implications for my medical treatment. I acknowledge that the results will be communicated to my healthcare provider.

**Patient's Signature:** ..... **Date:**

**Phlebotomist's or Collector's Information**

- **Name of Phlebotomist/Collector:**
- **Date and Time of Sample Collection:**
- **Sample Collection Method:**

**Laboratory Information**

- **Laboratory Requisition Number:**
- **Date Sent to the Laboratory:**
- **Expected Date of Test Results:**

**Physician's Comments and Orders**

- **Additional Comments or Specific Instructions:**
  
- **Any Other Laboratory Tests Ordered Concurrently:**

**Physician's Signature:** ..... **Date:**