Gamma-Glutamyl Transferase (GGT) Test Request Form

Patient Information

Patient Name: John Smith

Date of Birth: 01/15/1980

Gender (Male/Female/Other): Male

Address: 123 Main Street, Anytown, USA

Phone Number: (555) 555-5555

Email: john.smith@email.com

Medical History

Primary Care Physician: Dr. Jane Johnson

Relevant Medical Conditions: None reported

Medications (Include Dosage): Lisinopril 10mg daily Aspirin 81mg daily

Test Request

Reason for GGT Test: Routine health check-up and liver function assessment.

Additional Tests Requested (if any): None

Consent

I, the undersigned patient/legal guardian, hereby consent to the Gamma-Glutamyl Transferase (GGT) test as requested by my healthcare provider. I understand the purpose of this test and its implications.

Payment Information

Payment Method

☐ Cash

☐ Credit Card

☑ Insurance (Specify): XYZ Health Insurance

Laboratory Information

Preferred Laboratory: ABC Diagnostics

Special Instructions (if any): None

Healthcare Provider's Signature: Dr. Jane Johnson

Patient's/Legal Guardian's Signature: John Smith

Date: 10/18/2023