Growth Hormone Test Request Form

Patient Information

- **Patient Name:** Jane Smith
- **Date of Birth:** 08/15/2015
- **Gender (Male/Female/Other):** Female
- **Patient ID/Record Number:** 789012

Contact Information

- **Address:** 456 Oak Avenue, Smalltown, USA
- **Phone Number:** (555) 123-4567
- **Email Address:** janesmith@email.com

Clinical Information

- **Referring Physician:** Dr. Michael Johnson
- **Date of Referral:** 09/25/2023
- **Reason for Referral:**

  ☑ Short stature in a child

  ☐ Delayed growth in a child

  ☐ Growth hormone deficiency (child/adult)

  ☐ Suspected acromegaly (adult)

  ☐ Other (please specify): _____

Clinical Notes

Jane Smith, a 7-year-old female, is presenting with short stature concerns. She falls below the 5th percentile for her age group, and her growth over the past two years has been notably slower than expected. No other significant medical history or symptoms reported.

Test Details

- **Type of Test Requested**

  ☑ Basal Growth Hormone Test

  ☐ Growth Hormone Stimulation Test (e.g., with arginine or insulin)

- **Fasting Required (Yes/No):** No

- **Date/Time of Test:** 10/10/2023 at 10:00 AM
- **Test Location:** ABC Diagnostics
- **Additional Instructions:** None

Provider Information

- **Ordering Physician:** Dr. Michael Johnson
- **Medical License Number:** MD12345
- **Clinic/Practice Name:** Johnson Family Clinic
- **Contact Information**
  - **Address:** 789 Oak Street, Cityville, USA
  - **Phone Number:** (555) 123-4567
  - **Email Address:** dr.michael@email.com

Laboratory Information

- **Preferred Laboratory (if applicable):** XYZ Labs
- **Preferred Method of Receiving Results:**

  ☐ Fax

  ☑ Email (please provide email address)

  ☐ Other (please specify):

Patient Consent:

I, the undersigned, consent to administering the Growth Hormone Test as ordered by my healthcare provider. I understand the nature of the test, its purpose, and potential risks.

Patient Signature: Jane Smith

Date: 09/25/2023