Growth Hormone Test Request Form

Patient Information

- **Patient Name:**
- **Date of Birth:**
- **Gender (Male/Female/Other):**
- **Patient ID/Record Number:**

Contact Information

- **Address:**
- **Phone Number:**
- **Email Address:**

Clinical Information

- **Referring Physician:**
- **Date of Referral:**
- **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

Test Details

- **Type of Test Requested**
  - ☐ Basal Growth Hormone Test
  - ☐ Growth Hormone Stimulation Test (e.g., with arginine or insulin)
- **Fasting Required (Yes/No):**

- **Date/Time of Test:**
- **Test Location:**
- **Additional Instructions:**

Provider Information

- **Ordering Physician:**
- **Medical License Number:**
- **Clinic/Practice Name:**
- **Contact Information**
  - **Address:**
  - **Phone Number:**
  - **Email Address:**

Laboratory Information

- **Preferred Laboratory (if applicable):**
- **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:

Date: