

Haptoglobin Test Report

Patient's Name: _____

Date of Birth: _____ Gender: _____

Date of Test: _____

Reason for Testing:

Physician's Name and Signature: _____

Contact Information: _____

Test Results

- Haptoglobin Level: _____
- Reference Range (if applicable): _____

Interpretation:

Additional Notes (Clinical Implications, Recommendations, etc.):

Physician's Name: _____

Date: _____