Heavy Metal Blood Test Requisition Form

Patient Information

Patient Name: John Doe _____ Date of Birth: 01/15/1980 _____

Sex:

- [ ] Male
- [x] Female
- [ ] Other

Medical Record Number (if applicable): 123456 _____

Phone Number: (555) 555-5555 _____ Email Address: johndoe@email.com _____

Clinical Information

Reason for Heavy Metal Blood Test: Occupational exposure to heavy metals

Symptoms/Exposure History: Fatigue, headaches, lead-based paint exposure

Occupational/Environmental Risks: Works in a construction site with lead-based paint

Other Relevant Medical History: None

Requested Tests

- [x] Lead
- [ ] Mercury
- [ ] Cadmium
- [ ] Arsenic
- [ ] Other (Specify): _____

Special Instructions

- Fasting Required:
  - [ ] Yes
  - [x] No
- Avoid Specific Foods or Medications: None

- Specific Collection Time: Morning

- [x] Serum
- [ ] Plasma
- [ ] Whole Blood

Provider Information

Physician's Name: Dr. Jane Smith

Provider's NPI Number: 1234567890

Clinic/Hospital Name: ABC Medical Center

Contact Phone Number: (555) 123-4567

Billing Information

Insurance Provider: XYZ Health Insurance

Policy/ID Number: 987654321

Patient Consent

I, the undersigned patient or legal guardian, authorize collecting and analyzing my blood for the specified heavy metal tests. I understand these tests' purpose and potential risks and consent to releasing results to my healthcare provider.

Patient Signature: John Doe _____ Date: 10/10/2023 _____

For Laboratory Use Only

Sample Collection Date & Time: 10/12/2023 _____

Sample Labeling: Labeled as per protocol

Received By: Lab Technician _____ Lab Technician Date: 10/12/2023 _____

Test Results:

- [ ] Normal
- [ ] Abnormal
- [x] Pending

Comments/Notes:

Sample received. Results pending analysis.