

Heavy Metal Blood Test Requisition Form

Patient Information

Patient Name: _____ Date of Birth: _____

Sex:

- Male
- Female
- Other

Medical Record Number (if applicable): _____

Phone Number: _____ Email Address: _____

Clinical Information

Reason for Heavy Metal Blood Test:

Symptoms/Exposure History:

Occupational/Environmental Risks:

Other Relevant Medical History:

Requested Tests

- Lead
- Mercury
- Cadmium
- Arsenic
- Other (Specify): _____

Special Instructions

- Fasting Required:
 - Yes
 - No
- Avoid Specific Foods or Medications:

• Specific Collection Time:

- Serum
- Plasma
- Whole Blood

Provider Information

Physician's Name:

Provider's NPI Number:

Clinic/Hospital Name:

Contact Phone Number:

Billing Information

Insurance Provider:

Policy/ID Number:

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: _____ Date: _____

For Laboratory Use Only

Sample Collection Date & Time: _____

Sample Labeling:

Received By: _____ Lab Technician Date: _____

Test Results:

- Normal
- Abnormal
- Pending

Comments/Notes: