Hemoglobin A1C (HbA1c) Test

Name:	
Date of Birth:	
Sex:	
Date of Test:	
Reason for Test:	
Additional Notes:	
Name and Signature of Physician:	
Request Date:	

Patient Name:
Laboratory Name:
Contact Information:
Test Results • HbA1C Level: _____ • Target Range: _____ % to _____% • Date of Previous Test (if needed): _____ • Previous HbA1C (if needed/applicable): _____ • Interpretation:
Additional Notes (Treatment Plan, Next Steps, Instructions, etc.)

Physician's Name and Signature:

Date: