

Hemoglobin Test

Patient Information

Name:

Date of Birth:

Gender:

Patient ID:

Address:

Phone:

Email:

Physician Information

Referring Physician:

Clinic/Hospital:

Phone:

Email:

Test Information

Date of Test:

Time:

Reason for Hemoglobin Test:

Test Method

- Venous Blood Sample
- Capillary Blood Sample (Fingerstick)
- Heelstick (for infants)

Patient Preparation

- Fasting Required (If so, specify duration): _____
- No special preparation required

Clinical History

- Anemia
- Polycythemia Vera
- Weakness
- Fatigue
- Shortness of Breath
- Dizziness
- Other (Specify): _____

Additional Testing (if needed)

- Complete Blood Count (CBC)
- Iron Studies
- Vitamin B-12/Folate Levels
- Other (Specify): _____

Results

Hemoglobin Level: _____ grams per deciliter (g/dL)

- Normal Range for Men: 13.2 to 16.6 g/dL
- Normal Range for Women: 11.6 to 15 g/dL

Interpretation of Results:

Recommendations/Next Steps:

Provider Signature: _____ Date: _____

FOR LAB USE ONLY

Specimen ID: _____

Collector's Name: _____

Date/Time Collected: _____

Lab Technician: _____

Date/Time Received: _____

Laboratory Results:

Hemoglobin Level: _____ g/dL

Test Method: _____

Comments/Notes: