Immunofixation Blood Test Request Form

Patient Information

- **Patient Name:** John Doe
- **Date of Birth:** 01/15/1970
- **Gender:** Male
- **Medical Record Number:** 123456
- **Address:** 123 Main Street, Cityville, State, ZIP
- **Phone Number:** (555) 555-5555
- **Email:** john.doe@email.com

Referring Physician Information

- **Referring Physician Name:** Dr. Jane Smith
- **Medical License Number:** MD123456
- **Address:** 456 Medical Avenue, Townsville, State, ZIP
- **Phone Number:** (555) 123-4567
- **Email:** dr.jane.smith@email.com

Clinical Indication

- **Reason for Request:** Suspected multiple myeloma
- **Clinical Symptoms/History:**
  In recent blood work, Mr. Doe presents with bone pain, fatigue, and elevated calcium levels.

Test Request

- **Test Type:** Immunofixation Blood Test
- **Specimen Type:** Blood
- **Additional Tests (if applicable):** Comprehensive Metabolic Panel

Laboratory Information

- **Laboratory Name and Location:** City Medical Labs, 123 Main Street, Cityville, State, ZIP
- **Address:** 123 Main Street, Cityville, State, ZIP
- **Phone Number:** (555) 789-1234
- **Email:** info@citymedicallabs.com

Patient Preparation

- **No specific patient preparation instructions are required.**

Special Considerations

- **Patient allergies or contraindications:** None known.
- **Any other pertinent information:** Mr. Doe is not currently on any medication.

Provider's Notes:

- **Clinical notes or additional information:**

  Mr. Doe's recent physical examination showed signs of anemia, and reported persistent fatigue and discomfort. Given these symptoms and the potential for multiple myeloma, I request an Immunofixation Blood Test for further evaluation.

Signature

- **Referring Physician's Signature:** Dr. Jane Smith
- **Date:** 10/20/2023

Patient Consent

- **Patient Consent for the test (if required):** Mr. Doe has provided informed consent for the Immunofixation Blood Test.
- **Patient's Signature:** John Doe
- **Date:** 10/20/2023