Immunofixation Blood Test Request Form

Patient Information

- **Patient Name:**
- **Date of Birth:**
- **Gender:**
- **Medical Record Number:**
- **Address:**
- **Phone Number:**
- **Email:**

Referring Physician Information

- **Referring Physician Name:**
- **Medical License Number:**
- **Address:**
- **Phone Number:**
- **Email:**

Clinical Indication

- **Reason for Request:**
- **Clinical Symptoms/History:**

Test Request

- **Test Type:**
- **Specimen Type:**
- **Additional Tests (if applicable):**

Laboratory Information

- **Laboratory Name and Location:**
- **Address:**
- **Phone Number:**
- **Email:**

Patient Preparation

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

Special Considerations

- **Patient allergies or contraindications:**
- **Any other pertinent information:**

Provider's Notes:

- **Clinical notes or additional information:**

Signature

- **Referring Physician's Signature:**
- **Date:**

Patient Consent

- **Patient Consent for the test (if required):**
- **Patient's Signature:**
- **Date:**