Insulin Blood Test Requisition Form

Patient Information

- **Patient Name:** John Doe
- **Date of Birth:** 05/10/1980
- **Gender:** Male
- **Contact Information**
  - Address: 123 Main St, Anytown, USA
  - Phone Number: (555) 123-4567

Clinical Details

- **Relevant Medical History:** Patient has a history of type 2 diabetes.
- **Reason for Test:** Routine monitoring of insulin levels and glucose control.
- **Clinical Indications:** To assess the effectiveness of current medication regimen and make necessary adjustments.
- **Special Instructions:** Patient is fasting for 10 hours prior to the test.

Fasting Details

- **Fasting Duration:** 10 hours
- **Last Meal/Drink Time:** 10:00 PM the night before the test.

Insurance Information

- **Insurance Provider:** XYZ Health Insurance
- **Policy/ID Number:** 123456789

Healthcare Provider Information

- **Ordering Healthcare Provider:** Dr. Jane Smith
- **Provider's Contact Information**
  - Address: ABC Medical Clinic, 456 Oak St, Anytown, USA
  - Phone Number: (555) 987-6543

Patient Consent

I, the undersigned, authorize the performance of the Insulin Blood Test. I understand the purpose of this test and its implications. I consent to release the results to the ordering healthcare provider for evaluation and treatment.

Patient's Signature: John Doe

Date: 10/13/2023