

LDH Blood Test

Patient Information

- Name:
- Date of Birth:
- Medical Record Number:

Ordering Physician

- Name:
- Address:
- Phone Number:
- Email:

Test Information

- Test Name:
- Reason for Test:
- Clinical Indications:
- Additional Comments/Instructions:

Patient Preparation

- Fasting Required:
 - Yes
 - No
- Special Instruction for fasting:
- Medication Considerations:

Sample Collection

- Location:
- Date/Time:
- Phlebotomist/Nurse:

Laboratory Information

- **Laboratory Contact:**
- **Expected Turnaround Time:**

Result Interpretation

- **Normal LDH Range:**
- **Abnormal Results:**
 - Elevated
 - Decreased

Clinical Implications

-
- **Suggested Follow-up/Additional Tests:** ECG, Troponin levels, and consultation with a cardiologist.

Documentation and Reporting

-
-
-
-
-