Microalbumin Creatinine Ratio Test Request Form

Patient Information

- **Patient Name:**
- **Date of Birth:**
- **Medical Record Number:**
- **Date of Test Request:**

Clinical Information

- **Referring Physician:**
- **Reason for Test Request:**
- **Clinical Diagnosis or Suspected Condition:**

Test Details

- **Test Name:**
- **Lab Facility:**
- **Test Date:**

Patient Preparation

- **Explain the purpose of the test to the patient.**
- **Instruct the patient to collect a random urine sample.**

Sample Collection Instructions

- The patient should provide a fresh urine sample in a clean, sterile container.
- Inform the patient to void the first morning urine and collect all subsequent urine samples in 24 hours if a timed collection is required.
- Instruct the patient not to touch the inside of the container or contaminate the sample.

Laboratory Processing

- Transport the urine sample to the laboratory promptly.
- Inform the laboratory to measure microalbumin and creatinine levels to calculate the Microalbumin Creatinine Ratio.

Results and Follow-Up

- Results will be communicated to the referring physician.
- Interpret results from the patient's medical history and clinical condition.
- Consider appropriate interventions or further testing based on the results.

Physician's Signature: ..... **Date:**