

# Osmolality Blood Test Form

## Patient Information

Name:

Date of Birth:

Gender:

Address:

Phone:

Email:

## Test Preparation

Dietary Restrictions:

Medications:

Other Instructions:

## Test Experience

Previous Blood Tests:

Yes

No

Description (if yes):

## Reason for the Test

Reason for Test (Check all that apply):

Low sodium (hyponatremia) or water loss

Suspected poisoning

Problems producing urine

Other (please specify):

## Health History

Do you have any of the following medical conditions? (Check all that apply):

Diabetes insipidus

High blood sugar (hyperglycemia)

High sodium (hypernatremia)

Stroke or head trauma

Water loss (dehydration)

- Adrenal gland issues
- Lung cancer-related conditions
- Thyroid problems
- Other (please specify):

**Contact in Case of Emergency**

Emergency Contact Name:

Relationship to You:

Phone:

**Consent**

I, the undersigned, understand the purpose of the Osmolality blood test and agree to undergo this test as deemed necessary by my healthcare provider. I acknowledge that I have received and understood any specific instructions provided to prepare for the test.

Patient's Signature:

Date: