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: