Osmolar Gap Test Request Form

Patient Information

Patient Name: ___________________________

Date of Birth: ___________________________

Medical Record Number (if applicable): ___________________________

Date and Time of Sample Collection: ___________________________

Clinical Information

Referring Physician: ___________________________

Clinical Indication: ____

Suspected Diagnosis/Condition (if applicable): ____

Relevant Clinical History: ____

Specimen Collection

Specimen Type:

- [ ] Serum
- [ ] Plasma

Specimen Volume: ___________________________

Specimen Collection Method: ___________________________

Additional Notes on Specimen Handling: ____

Laboratory Information

Name of Laboratory/Testing Facility: ____

Specimen Received Date and Time: ___________________________

Osmolar Gap Test

Reference Range for Osmolar Gap: ___________________________

Method of Osmolality Measurement: ____

Laboratory Technician/Phlebotomist: ___________________________

Clinical Assessment

Interpretation of Osmolar Gap:

Recommendations for Clinical Management:

Additional Tests or Consultations (if indicated):

Physician's Signature: Dr. Jane Smith

Date: ____________________________