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: _____

Date: _____