Prothrombin Time (PT) Test Request Form

Patient Information

- Full Name:
- Date of Birth:
- Sex:
- Medical Record Number (if applicable):
- Contact Information:

Ordering Physician

- Name:
- Medical License Number:
- Contact Information:

Clinical Indication

Specimen Collection Details

- Date and Time of Collection:
- Sample Type:

Anticoagulant Medication Status (if applicable)

Special Instructions

Patient Consent