

Salicylates Level Test

Patient's Name:

Date of Birth:

Gender:

Clinical Indication/Reason for Test:

- Suspected Aspirin Poisoning
- Monitoring of Prescription-Strength Aspirin Therapy
- Emergency: Suspected Salicylate Ingestion
- Other: _____

Symptoms or Additional Notes (if applicable):

Special Instructions or Notes:

- Fast prior to the test.
- Refrain from aspirin or medication containing salicylate for at least 4 hours before the test.
- The test may need to be repeated at specified intervals for monitoring.

Date of Test Request:

Ordering Physician's Name and Signature:

Ordering Physician's Contact Information:

Laboratory Name:

Laboratory Contact Number:

Collection Date and Time:

Laboratory Technician's Name and Signature:

Test Results:

- Salicylates Level Test:
- Reference Range:
- Interpretation (if needed):

Additional Notes:

Ordering Physician's Name and Signature: _____

Date: _____