## **Sodium Blood Test**

Patient's Name:	
Date of Birth:	
Gender:	
Contact Information:	
Reason for Test:	
Routine Checkup	
Dietary Habits	
Serious Illness	
Surgery	
Intravenous Fluid Administration	
Medication Monitoring	
Symptoms of Sodium Imbalance	
(Symptoms:	)
Other:	
Additional Notes:	

**Referring Physician's Name and Signature:** 

**Request Date:** 

Laboratory Name:

Laboratory Contact Information:

Date and Time of Sample Collection:

## **Test Results**

- Sodium Level: \_\_\_\_\_ mEq/L
- Reference Range: 135-145 mEq/L

Interpretation:

Additional Notes (Recommended Actions, Treatments, Follow-up Tests, etc.):

Referring Physician's Name and Signature:

Date: