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: