Spinal Fluid Test

Patient Information
Patient Name:
Date of Birth:
Gender:
Phone Number:
Known Allergies:
Medical Conditions:
Current Medications:

Type of Test: CSF Analysis
Date of Test:
Ordering Physician:
Reason for Testing:

CSF Analysis Results

Tested Parameters	Results
Appearance:	
Color:	
Pressure:	
Total Protein (mg/dL):	
Glucose (mg/dL):	
Cell Count:	
White Blood Cells (WBC):	
Red Blood Cells (RBC):	

Differential Cell Count:

Neutrophils (%): _____________

Lymphocytes (%): ____________

Monocytes (%): _____________

Eosinophils (%): _____________

Other (specify): ____

Microbiological Examination (if applicable): _______________________________________

Interpretation of Results

Treatment Recommendations
Allergen Avoidance:
Prescription for Allergy Management:
Immunotherapy:

Follow-Up:

________________________________ ________________________

Healthcare Provider Signature **Patient Signature**