# 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**

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| **Treatment Recommendations** |
|---|
| Allergen Avoidance: |
| Prescription for Allergy Management: |
| Immunotherapy: |

**Follow-Up:**

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_____ _____

**Healthcare Provider Signature** **Patient Signature**