

Strep A Test

Patient Name:

Date of Birth:

Address:

Contact Information:

Reason for Strep A Test:

Symptoms:

- Sudden and severe sore throat
- Pain/difficulty swallowing
- Fever of 101°F/38.3°C or more
- Sore, red throat with white patches
- Headache
- Chills
- Loss of appetite
- Swollen lymph nodes in the neck
- Other: _____

Additional Notes:

Test Type Requested:

- Rapid Strep Test
- Throat Culture
- Other: _____

Referring Physician's Name and Signature:

Request Date:

Laboratory Name:

Laboratory Address:

Laboratory Contact Information:

Laboratory Technician:

Test Type:

Sample Collection Date and Time:

Test Results:

- Positive: Presence of Strep A infection
- Negative: Absence of Strep A infection

Clinical Interpretation:

Treatment Plan (if applicable):

Additional Notes:

Referring Physician's Name and Signature:

Date: