Strep B or GBS Test

Patient's Name:

Date of Birth:

Contact Information:

Gestational Age:

Expected Due Date:

Current Week of Pregnancy:

Previous GBS Status (if applicable):

Known Allergies (if any):

Other Relevant Medical History:

Clinical Justification for GBS Test (Reason for Testing):

Referring Physician's Name and Signature:

Request Date:

Laboratory Name:

Laboratory Address:

Laboratory Contact Information:

Date and Time of Sample Collection:

Sample Collection Site/s:

Test Results:

- GBS Test Result

☐ Positive

☐ Negative

☐ Inconclusive

Date of Test Result:

Interpreting Physician's Name and Signature:

Interpretation of Results (Summary of test results, implications, etc.):

Recommendations:

- **Treatment Recommendations (if applicable):**
- **Follow-up or Additional Testing Needed:**

Additional Notes: