

# Thyroid Panel Test Requisition Form

## Patient Information

Patient Name:

Date of Birth:

Gender:

Contact Number:

Medical Record Number (if applicable):

Primary Care Physician:

## Clinical Information

- **Reason for Test:**

- Symptoms
- Routine Screening
- Thyroid Disorder Monitoring
- Pregnancy
- Other (please specify): \_\_\_\_\_

- **Clinical Symptoms:**

- **Pregnancy Status (if applicable):**

- Pregnant
- Not Pregnant
- N/A

- **Relevant Medical History:**

## Thyroid Panel Test Selection

- Basic Thyroid Panel (TSH, Free T4)
- Comprehensive Thyroid Panel (TSH, Free T4, Free T3)
- Thyroid Antibodies (TPOAb, TgAb)
- Other (please specify): \_\_\_\_\_

**Billing Information**

- Insurance Provider (if applicable):
- Policy/ID Number:

**Consent and Authorization**

I, the undersigned, authorize and consent to the Thyroid Panel Test. I understand that the test may involve the collection and analysis of blood samples. I acknowledge that the results will be shared with my healthcare provider for diagnostic and treatment purposes.

**Patient's Signature:****Date:**