

Triglycerides Test

Patient Name:

Date of Birth:

Gender:

Contact Information:

Reason for Test:

Known Medical Conditions, Medications, or Allergies, etc.:

Previous Triglycerides Test (if applicable)

- Date of Last Test:
- Results of the Last Test:

Referring Physician's Name and Signature:

Request Date:

Laboratory Name:

Laboratory Address:

Laboratory Contact Information:

Date and Time of Sample Collection:

Test Results

- Triglycerides Level: _____ mg/dL

Interpretation

- Normal: Less than 150 mg/dL
- Borderline High: Between 150 and 199 mg/dL
- High: Between 200 and 499 mg/dL
- Very High: Equal to or higher than 500 mg/dL

Recommendations:

- No further action is required
- Lifestyle Modifications
- Medical Interventions and lifestyle changes
- Other: _____

Additional Notes:

Referring Physician's Name and Signature:

Date: