Order for UIBC Blood Test

Patient Information

Name:

Date of Birth:

Gender:

Address:

Phone:

Email:

Patient History

Clinical Indication:

Symptoms:

Medical History:

Medications:

Allergies:

Test Details

Test Name:

Reason for Test:

Additional Tests Ordered:

Special Instructions:

Fasting Required:

☐ Yes

☐ No (12 hours)

Sample Collection

Location:

Date and Time:

Laboratory Information

Preferred Laboratory:

Address:

Contact:

Fax:

Results and Reporting

Results to be reported to:

Specify preferred method:

- ☐ Phone
- ☐ Email
- ☐ Fax
- ☐ Mail

Expected result delivery time:

Physician's Information

Physician's Name:

Medical License Number:

Contact Information:

Patient Consent:

I, the undersigned, consent to the Unbound Iron-Binding Capacity (UIBC) Blood Test and any additional tests as indicated. I understand the purpose, potential risks, and benefits of the test, and I authorize the release of the test results to the specified parties.

Patient's Signature: