BILIRUBIN BLOOD TEST REQUISITION FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ dd / mm / yyyy

What is your gender?

◯ Male ◯ Female

Email: _____ Phone Number: _____

Street Address: _____ City: _____

Postcode: _____ Medical Record Number: _____

HEALTHCARE PROVIDER INFORMATION

Provider Name: _____ Medical License Number: _____

Clinic/Hospital Name: _____ Phone Number: _____

Fax Number: _____

TEST SPECIFICATIONS: TEST REQUESTED: BILIRUBIN BLOOD TEST

Clinical Indication (Reason for Test)

Additional Notes/Instructions

PATIENT CONSENT

I, the undersigned patient or legal guardian, hereby consent to perform the Bilirubin Blood Test as ordered by my healthcare provider. I understand the nature of the test, its purpose, and the potential risks and benefits.

Patient Signature

Date: _____ dd / mm / yyyy

FOR OFFICE USE ONLY

Date and Time of Collection: _____ Phlebotomist/Collector Name: _____

Laboratory Processing Date: _____ dd / mm / yyyy Total Bilirubin (mg/dL): _____

Direct Bilirubin (mg/dL): _____ Indirect Bilirubin (mg/dL): _____

Provider Signature

Date: _____ dd / mm / yyyy