MEDLINE PATHOCARE
Your trusted partner in diagnostics

LABORATORY TEST REQUEST FORM

Patient Information

Full Name: .....
Patient ID/Number:
.....Age: ..... Gender:
.....Contact (Address/Phone/Email): .....

Medical History

Known Allergies: .....
Current Medications: .....
Pre-existing Conditions: .....

Requester Information

Requesting Physician/Doctor/Clinician: .....
Department: .....
Signature: .....
Phone: .....Email/Fax: .....
Referring Facility Name & Location: .....

Sample Information

Sample Type: .....
Container/Preservative Used: .....
Date of Collection: ..... Time: ..... Collection Location: .....

Test Information

Requested Tests: .....
.....
.....
.....
.....
Clinical Indication (Symptoms/Diagnosi):
.....
.....

Submission Details [To be filled by the referral Laboratory]

Date of Submission: .....Time: .....
Any special Instructions: .....

Please fill in all sections clearly and legibly. Ensure patient identification and sample collection details are accurate. Incomplete forms may delay processing. Attach any relevant documents or clinical notes if necessary.