Smart Institute of Rehabilitation Medicine

TEST ORDERING FORM

Patient Information

MR No. _____ **Name:** _____

Age: _____ **Gender:** _____

Clinical History _____

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Lab				Radiology		Others	
CBC	☐	AST	☐	X-Ray	☐	Physiotherapy	☐
EBR	☐	HbsAg	☐	DXA Scan	☐	Occupational Therapy	☐
Blood Gp	☐	Hcv A/b	☐	NCS	☐	Speech Therapy	☐
BSF	☐	HIV A/b	☐	EMG	☐	Psychotherapy	☐
BSR	☐	VDRL	☐			Nutrition Therapy	☐
RFT	☐	ICT TB	☐				
LFT	☐	ICT MP	☐				
Lipid Profile	☐	Typhi dot	☐				
S. T. protein	☐	RA Factor	☐				
S. Albumin	☐	ASOT	☐				
CPK	☐	Urine R/E	☐				
CKMB	☐	Urine P. T	☐				

Name of Ordering Physician_____

Signature

(Stamp)