Name of Hospital:

Add the logo of your hospital / laboratory here

Department of _____

Name of Patient :	Age of Patient :	Central Registration Number :
Ward/OPD :	Consultant Number :	Contact number of Patient:
Sample ID :	Diagnosis :	

Drug/Drugs to be Evaluated :	Dose/Frequency/ Route of Drug/Durgs :	Duration of Drug/Drugs Received :
Time of Last Dose of Drug/Drugs :		Time of Sample Collection :

Reason for Evaluation : Suspected toxicity/Tnadequate response/ Drug interaction/ Patient compliance :

Concomitant Drugs :

Serum Albumin : _____

Drug Concentration Measured : _____

Interpretation and Advice :

Signature of Chief of Lab

Signature of Doctor