

Hospital No.:

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LABORATORY TEST REQUEST FORM
Accession No.:

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I. PATIENT INFORMATION: (to be filled-up by requisitioner)																				
Name: (First, Middle, Last)										Date of Birth: (MM/DD/YYYY)										
Address: (Street, Barangay, District, Municipality, Province, Region)										Sex: <input type="checkbox"/> M <input type="checkbox"/> F			Age: (YY.MM)							
Clinical Impression:					Location/ <input type="checkbox"/> OPD <input type="checkbox"/> Referral Classification: <input type="checkbox"/> AS <input type="checkbox"/> RITM INPATIENT ____					Date of Admission: (MM/DD/YYYY)										
					Suspected Agent:					Date of Onset of Illness: (MM/DD/YYYY)										

II. REQUISITIONER INFORMATION: (to be filled-up by requisitioner)					
Requisitioner (MD)/Disease Surveillance Officer Name:		Address:		Requisitioner (MD)/DRU Contact Details: (at least 1)	
				Tel No.: _____	
Name of Disease		Type of DRU:	Region:	Province:	Municipality:
Reporting Unit (DRU):					
				Fax No.: _____	
				Cell No.: _____	
				Email Address: _____	

III. SPECIMEN INFORMATION: (to be filled-up by requisitioner for pre-collected specimens or RITM staff)	
Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> Cerebrospinal Fluid <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Tissue <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Abscess Aspirate <input type="checkbox"/> Others _____	Date and Time of Specimen Collection: (MM/DD/YYYY HR:MIN)
Anatomic Site of Origin (if appropriate): _____	Collected by: printed name & signature

IV. HOSPITAL INFORMATION: (to be filled-up by RITM staff)																			
Laboratory Number:								Official Receipt No.:								Specimen Acceptable: <input type="checkbox"/> YES <input type="checkbox"/> NO (reason) _____			
Date and Time of Specimen Receipt: (MM/DD/YYYY- HR:MIN)								Received by: printed name & signature											

V. LABORATORY TESTS: (to be filled-up by requisitioner- please mark with an "x" box of the requested examination) ☐ STAT Request

CLINICAL LABORATORY					
HEMATOLOGY	Smear	PULMONARY	LIPID PROFILE	LIVER FUNCTION TEST	BODY FLUID CHEMISTRIES
<input type="checkbox"/> Complete blood count w/ platelet	<input type="checkbox"/> Coagulation Time	<input type="checkbox"/> Arterial Blood Gas (ABG)	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Albumin (A)	<input type="checkbox"/> CSF Glucose
<input type="checkbox"/> Hemoglobin & Hematocrit	<input type="checkbox"/> Prothrombin Time		<input type="checkbox"/> HDL	<input type="checkbox"/> Alkaline Phosphatase	<input type="checkbox"/> CSF Protein
<input type="checkbox"/> Reticulocyte count	<input type="checkbox"/> Partial Thromboplastin Time	GLUCOSE	<input type="checkbox"/> LDL	<input type="checkbox"/> Total Protein (TP)	<input type="checkbox"/> 24 hour Urine Creatinine
<input type="checkbox"/> Erythrocyte Sedimentation Rate	BLOOD BANK	<input type="checkbox"/> Fasting Blood Sugar	<input type="checkbox"/> Triglyceride	<input type="checkbox"/> Globulin (G)	<input type="checkbox"/> 24 hour Urine Protine
<input type="checkbox"/> Clot Retraction Time	<input type="checkbox"/> Blood Typing	<input type="checkbox"/> Oral Glucose Tolerance Test		<input type="checkbox"/> TPA/G	<input type="checkbox"/> Creatinine Clearance
<input type="checkbox"/> Clotting Time	<input type="checkbox"/> Coomb's Test (Direct)	<input type="checkbox"/> Random Blood Sugar	ELECTROLYTES	<input type="checkbox"/> A/G Ratio	
<input type="checkbox"/> Bleeding Time	<input type="checkbox"/> Coomb's Test (Indirect)	<input type="checkbox"/> Glucose 1 hr Challenge Test	<input type="checkbox"/> Sodium	<input type="checkbox"/> Bilirubin, Direct	OTHER CHEMISTRIES
<input type="checkbox"/> Lupus Erythematosus (LE) Preparation	<input type="checkbox"/> Cross-matching	<input type="checkbox"/> HbA1C	<input type="checkbox"/> Potassium	<input type="checkbox"/> Bilirubin, Indirect	<input type="checkbox"/> Amylase
<input type="checkbox"/> Peripheral Blood	CLINICAL MICROSCOPY	POSTPRANDIAL BLOOD SUGAR (PPBS)	<input type="checkbox"/> Calcium	<input type="checkbox"/> Bilirubin, Total	<input type="checkbox"/> CPK
	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> 1 hr PPBS	<input type="checkbox"/> Chloride	<input type="checkbox"/> Bilirubin (Total,Direct, indirect)	<input type="checkbox"/> LDH
	<input type="checkbox"/> Cell count/differential	<input type="checkbox"/> 2 hr PPBS	<input type="checkbox"/> Inorganic Phosphorus	<input type="checkbox"/> SGOT/AST	<input type="checkbox"/> Uric Acid
		<input type="checkbox"/> 3 hr PPBS	<input type="checkbox"/> Magnesium	<input type="checkbox"/> SGPT/ALT	
			RENAL FUNCTION TEST		
			<input type="checkbox"/> BUN		
			<input type="checkbox"/> Creatinine		

☐ OTHERS
