



Laboratory Tests Request Form

Patient Name									اسم المريض الرباعي	
ID. No									رقم الهوية/ الإقامة	
Mobile No.									رقم الجوال	
Date of Birth									تاريخ الميلاد	
Nationality		الجنسية	Gender	Female	Male					الجنس
Referring Facility										

Relevant clinical information:
Diagnosis:
.....
Clinical information (History, Examination, medication):
.....

Essential Laboratory List:

HEMATOLOGY	CLINICAL CHEMISTRY	HORMONES	SEROLOGY/ IMMUNOLOGY	
<input type="checkbox"/> Coagulation Factor Specify: <input type="checkbox"/> Anti-Factor Xa <input type="checkbox"/> D Dimer <input type="checkbox"/> Malaria Film <input type="checkbox"/> Thrombophilia Screening Specify: <input type="checkbox"/> Lupus Anticoagulant <input type="checkbox"/> Mixing Study <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> Peripheral Blood Smear <input type="checkbox"/> Bone Marrow Aspirate <input type="checkbox"/> Bone Marrow Biopsy	<input type="checkbox"/> Amikacin <input type="checkbox"/> Trough <input type="checkbox"/> Peak <input type="checkbox"/> Vancomycin <input type="checkbox"/> Trough <input type="checkbox"/> Peak <input type="checkbox"/> Gentamicin <input type="checkbox"/> Trough <input type="checkbox"/> Peak <input type="checkbox"/> Digoxin <input type="checkbox"/> Phenytoin <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Valproic Acid (Depakine) <input type="checkbox"/> Carbamazepine <input type="checkbox"/> Theophylline <input type="checkbox"/> Troponin <input type="checkbox"/> CK MB <input type="checkbox"/> BNP <input type="checkbox"/> Lipase <input type="checkbox"/> Mg <input type="checkbox"/> Phosphorus <input type="checkbox"/> Calcium <input type="checkbox"/> Alk Phos <input type="checkbox"/> Albumin	<input type="checkbox"/> B-HCG <input type="checkbox"/> TSH <input type="checkbox"/> FT4 <input type="checkbox"/> FT3 <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> Progesterone <input type="checkbox"/> Estradiol <input type="checkbox"/> Prolactin <input type="checkbox"/> Vitamin D <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> PSA Total <input type="checkbox"/> PSA Free <input type="checkbox"/> GH Basal <input type="checkbox"/> GH Stimulation <input type="checkbox"/> Insulin <input type="checkbox"/> Glucagon <input type="checkbox"/> Clonidine <input type="checkbox"/> Tumor Marker Specify:	<input type="checkbox"/> Anti-thyroglobulin <input type="checkbox"/> Anti TPO <input type="checkbox"/> ANA <input type="checkbox"/> Ant ds DNA <input type="checkbox"/> ENA Specify: <input type="checkbox"/> EBV (IgG) <input type="checkbox"/> EBV (IgM) <input type="checkbox"/> RPR <input type="checkbox"/> Syphilis Serology <input type="checkbox"/> HAV IgM <input type="checkbox"/> H Pylori IgG <input type="checkbox"/> Anticardiolipin IgG <input type="checkbox"/> Anticardiolipin IgM	<input type="checkbox"/> CMV(IgG) <input type="checkbox"/> CMV (IgM) <input type="checkbox"/> HCV Antibody <input type="checkbox"/> Hepatitis B surface Antigen (HBsAg) <input type="checkbox"/> Hepatitis B surface Antibody(HBsAb) <input type="checkbox"/> Hepatitis B core Total Antibody (HBcAb). <input type="checkbox"/> HIV1,2 Ag/Ab <input type="checkbox"/> Rubella(IgG) <input type="checkbox"/> Toxoplasma (IgG) <input type="checkbox"/> Toxoplasma (IgM) <input type="checkbox"/> Herpes simplex virus1 (IgG,IgM) <input type="checkbox"/> Herpes simplex virus2 (IgG,IgM)
			MICROBIOLOGY	
			<input type="checkbox"/> H Pylori Antigen in Stool	
			<input type="checkbox"/> Beta- d- Glucan Test	

Other Tests:

Physician Name	Signature and Stamp	Date
Received By	Signature	Date

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