

Growth Hormone Test Request Form

Patient Information

- Patient Name:
- Date of Birth:
- Gender (Male/Female/Other):
- Patient ID/Record Number:

Contact Information

- Address:
- Phone Number:
- Email Address:

Clinical Information

- Referring Physician:
- Date of Referral:
- Reason for Referral:
 - ☐ Short stature in a child
 - ☐ Delayed growth in a child
 - ☐ Growth hormone deficiency (child/adult)
 - ☐ Suspected acromegaly (adult)
 - ☐ Other (please specify): _____

Clinical Notes

Test Details

- Type of Test Requested
 - ☐ Basal Growth Hormone Test
 - ☐ Growth Hormone Stimulation Test (e.g., with arginine or insulin)
- Fasting Required (Yes/No):

- **Date/Time of Test:**
- **Test Location:**
- **Additional Instructions:**

Provider Information

- **Ordering Physician:**
- **Medical License Number:**
- **Clinic/Practice Name:**
- **Contact Information**
 - **Address:**
 - **Phone Number:**
 - **Email Address:**

Laboratory Information

- **Preferred Laboratory (if applicable):**
- **Preferred Method of Receiving Results:**
 - ☐ Fax
 - ☐ Email (please provide email address)
 - ☐ Other (please specify):

Patient Consent:

I, the undersigned, consent to administering the Growth Hormone Test as ordered by my healthcare provider. I understand the nature of the test, its purpose, and potential risks.

Patient Signature:

Date: