

Hemoglobin Test

Patient Information

Name:

Date of Birth:

Gender:

Patient ID:

Address:

Phone:

Email:

Physician Information

Referring Physician:

Clinic/Hospital:

Phone:

Email:

Test Information

Date of Test:

Time:

Reason for Hemoglobin Test:

Test Method

- ☐ Venous Blood Sample
- ☐ Capillary Blood Sample (Fingerstick)
- ☐ Heelstick (for infants)

Patient Preparation

- ☐ Fasting Required (If so, specify duration): _____
- ☐ No special preparation required

Clinical History

- ☐ Anemia
- ☐ Polycythemia Vera
- ☐ Weakness
- ☐ Fatigue
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Other (Specify): _____

Additional Testing (if needed)

- ☐ Complete Blood Count (CBC)
- ☐ Iron Studies
- ☐ Vitamin B-12/Folate Levels
- ☐ Other (Specify): _____

Results

Hemoglobin Level: _____ grams per deciliter (g/dL)

- ☐ Normal Range for Men: 13.2 to 16.6 g/dL
- ☐ Normal Range for Women: 11.6 to 15 g/dL

Interpretation of Results:

Recommendations/Next Steps:

Provider Signature: _____ Date: _____

FOR LAB USE ONLY

Specimen ID: _____

Collector's Name: _____

Date/Time Collected: _____

Lab Technician: _____

Date/Time Received: _____

Laboratory Results:

Hemoglobin Level: _____ g/dL

Test Method: _____

Comments/Notes: