# Lab Test Referral Request

**Date:** [Insert Date]

**To:** [Lab Name]

**Address:** [Lab Address]

**Phone:** [Lab Phone Number]

## Referring Physician

**Name:** [Your Name]

**Practice Name:** [Practice Name]

**Phone:** [Your Phone Number]

**Fax:** [Your Fax Number]

## Patient Information

**Name:** [Patient's Name]

**Date of Birth:** [Patient's Date of Birth]

**Medical Record Number:** [Patient's MRN]

## Test Requested

Please perform the following test:

- Comprehensive Metabolic Panel (CMP)

## Clinical Information

[Insert relevant clinical information and reason for referral]

## Additional Notes

[Insert any additional instructions or requests]

Thank you for your assistance.

Sincerely,

[Your Name]

[Your Title]