Lab Test Referral Request

Date: [Insert Date]

Referring Physician: [Insert Physician's Name]

Practice Address: [Insert Practice Address]

Phone Number: [Insert Phone Number]

Patient Name: [Insert Patient's Name]

Patient Date of Birth: [Insert Patient's DOB]

Patient ID: [Insert Patient ID]

Referral Details

Dear [Lab Name/Recipient],

I am referring the above-named patient for infectious disease screening. Please perform the following tests:

- [Test Name 1]
- [Test Name 2]
- [Test Name 3]

Clinical Information:

[Insert relevant clinical history and reason for referral]

Additional Notes

Please report the findings directly to my office. Should you have any queries regarding this referral, do not hesitate to contact me.

Thank you for your attention to this matter.

Sincerely,

[Insert Physician's Name]

[Insert Physician's Signature]