Lab Test Referral Request

From: Dr. John Smith

Date: October 10, 2023

To: [Laboratory Name]

Address: [Laboratory Address]

Patient Information:

Name: [Patient Name]

Date of Birth: [Patient DOB]

Parents/Guardians: [Parent/Guardian Names]

Contact Number: [Contact Number]

Referral Details:

Please perform the following tests:

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

Clinical Information:

[Brief description of clinical concerns and reasons for testing]

Signature:

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Dr. John Smith, MD