Thyroid Function Test Lab Request

Patient Name
_____

Date of Birth
_____

Gender
_____

Date of Request
_____

Patient ID / MRN
_____

Contact Number
_____

Physician
_____

Requested Tests

TEST	MARK IF REQUESTED
Thyroid Stimulating Hormone (TSH)	☐
Free T4 (FT4)	☐
Free T3 (FT3)	☐
Total T4	☐
Total T3	☐
Anti-Thyroid Peroxidase Antibody (Anti-TPO)	☐
Anti-Thyroglobulin Antibody (Anti-Tg)	☐
Others (Specify)	☐

Clinical Information / Notes
_____

Requesting Physician's Signature
_____

Name & License No.
_____