

Test Result Transmission Record

Transmission Details

Date of Transmission:

Transmitting Facility:

Recipient Facility/Organization:

Mode of Transmission:

Transmitted By (Name):

Patient Information

Patient Name:

Patient ID/Number:

Date of Birth:

Test Performed:

Test Result Details

| Test Name | Result | Reference Range | Date Performed |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Confirmation

Received By (Name):

Date Received: