# Test Results Notification

***To Physician / Health Care Provider:*** *You are receiving this form to facilitate you maintaining an accurate and complete patient record and to avoid duplication of interventions.*

***Notification Information***

Health Care Professional Notified:

Notification Date:

Method: ☐ Fax _____ ☐ Phone _____ ☐ Other _____

***Patient Information***

| Name: | Health Card #: | Age: |
|---|---|---|

Informed Consent provided by: ☐ Patient ☐ Patient's Agent (specify agent name) _____

***Information on Test Ordered***

| Test Name: | Test Date: |
|---|---|
| Rationale for Test: | Test Result: |

Other Details (if applicable):

***Follow-up Plan (if applicable)***

| Therapeutic Goal | Follow-up Action(s) to be Undertaken | Date for Follow-up | Individual Responsible for Follow-up |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***Notes***:

***Pharmacist Information***

Name: Phone: Fax:

Pharmacy: