Patient Name: _____ Patient Age: |____|____| . |____|

Patient Sex: Male ☐ Female ☐

FORM HIFC2 - RENAL FUNCTION TEST RESULTS

Date of Test: |___||___| / |___||___| / |___||___||___||___| or Not Done ☐1 _____
Day Month Year

CHECK "N/A" FOR ANY RESULT THAT IS NOT AVAILABLE

	Renal Function Tests	N/A	Results	Units *(specify if "Other")*	Volume
a)	LDH	☐1	|___|___|___|___|___|.|___|___|	☐1 mg ☐5 mmol ☐2 g ☐6 IU ☐3 µmol ☐7 U ☐4 nmol ☐8 Other: *Specify:*	☐1 mL ☐2 dL/% ☐3 L
b)	BUN	☐1	|___|___|___|___|___|.|___|___|	☐1 mg ☐5 mmol ☐2 g ☐6 IU ☐3 µmol ☐7 U ☐4 nmol ☐8 Other: *Specify:*	☐1 mL ☐2 dL/% ☐3 L
c)	Creatinine	☐1	|___|___|___|___|___|.|___|___|	☐1 mg ☐5 mmol ☐2 g ☐6 IU ☐3 µmol ☐7 U ☐4 nmol ☐8 Other: *Specify:*	☐1 mL ☐2 dL/% ☐3 L
d)	Uric Acid	☐1	|___|___|___|___|___|.|___|___|	☐1 mg ☐5 mmol ☐2 g ☐6 IU ☐3 µmol ☐7 U ☐4 nmol ☐8 Other: *Specify:*	☐1 mL ☐2 dL/% ☐3 L
e)	Phosphorus	☐1	|___|___|___|___|___|.|___|___|	☐1 mg ☐5 mmol ☐2 g ☐6 IU ☐3 µmol ☐7 U ☐4 nmol ☐8 Other: *Specify:*	☐1 mL ☐2 dL/% ☐3 L

Hospital ID
(stick label here)

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