



**Malik
Eye Care**

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www.MalikEyeCare.com • Toll Free 1-844-Malik-2020

LABORATORY TESTING FORM

Patient _____ DOB _____

Date _____

Diagnosis _____

Please perform the following circled tests

CBC with Differential, ESR, C-Reactive Protein, SMA-18,
Glucose, HgbA1C, Lipid Profile, Homocysteine Level, PT/PTT,
ANA, AntiCardioLipin Abs, ACE, ANCA (P and C), RF, RPR,
FTA Abs, Lyme Titers, HLA-B27, HLA-A29, Toxoplasmosis Titers (IgG, IgM),
Toxocara Titers, Serum Viscosity

Other _____

Please Fax the results to the appropriate office above.

Signature _____