PERCURO CLINICAL RESEARCH LTD.

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FECAL CALPROTECTIN REFERRAL FORM

PATIENT NAME: Last/First	
PATIENT DOB: dd/mmm/yyyy	
PATIENT PHN:	
PATIENT CONTACT INFORMATION:	

ORDERING PHYSICIAN: Print Name	
AUTHORIZING GASTROENTEROLOGIST IF NOT ORDERING PHYSICIAN:	
PHYSICIAN SIGNATURE & DATE:	X Date: dd / mmm / yyyy
PHYSICIAN FAX:	

PRIOR DIAGNOSIS OF IBD:	☐ Yes ☐ No
BIOLOGIC TREATMENT:	☐ Yes: _____ ☐ No If Yes, start date: _____

FOR PERCURO LAB USE ONLY

DATE SAMPLE COLLECTED:	
DATE SAMPLE RECEIVED:	
DATE TEST PERFORMED:	
TEST RESULTS:	
TEST PERFORMED BY: Name & Signature	

REFERENCE RANGES

< 50	No evidence of inflammation – Probable IBS or Quiescent IBD
50-150	Indeterminate – Consider Referral
> 150	Query IBD – Evidence of mucosal inflammation