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PATIENT NAME: ________________________________ **DOB:** ____/_____/_________

FASTING: ☐ **YES** ☐ **NO**

DIAGNOSIS: 1) **Chronic diarrhea (K59.1)** 2) **Mal – absorption (K90)** 3) **CBH (R 19.4)**

Other diagnosis: ____

√	**LAB TEST**
	Serotonin level blood
	Pancreatic polypeptide
	Neuron Specific Enolase
	Chromogranin A level
	Substance P, EIA
	Serum Gastric level
	Serum Insulin level
	Porphobilinogen , Quantitative Random Urine
	5-HIAA, 24 hr Urine

SIGNATURE ________________ **DATE**______/______/___________

****IT IS THE PATIENT'S RESPONSIBILITY TO USE A FACILITY COVERED BY THEIR INSURANCE**.**
**** If you are going to LABCORP, You need to call the draw station in advance and make sure they have a Z tube to perform all the necessary tests ****