بسم الله الرحمن الرحيم

STATE OF KUWAIT
MINISTRY OF HEALTH
As'ad Al-Hamad
Dermatology Department
Al-Sabah Hospital

دولة الكويت
وزارة الصحة
مركز أسعد الحمد للأمراض الجلدية
مستشفى الصباح

LABORATORY EXAMINATION REQUEST FORM

IMMUNOLOGY

Name of Patient: ..... **Age:**..... **. Sex:** ..... **. Nationality:** ..... **.**
Residence: ..... **Referring Center:**..... **.**
Nature of Specimen: .....**Examination Required:** ..... **.**
Short History: .....
..... **.**
Clinical Diagnosis: ..... **.**
Doctor's Stamp and Signature : ..... **. Date:**...../...../..... **.**

LAB. USE ONLY	RESULTS	LAB. NO.:

- **Immunofluorescence Examination:**
  - **DIF:** .....
    .....

  IgG:..... **IgM:**..... **IgA:** .....
  C_3:..... **C_4:**..... **Fib.:** .....

  - **IIF:** .....
    .....

  ICS: .....
  BM: .....
- **Other Examinations:**
  - **Leishmania Smear:** .....
    .....
  - **Tzank's Smear:** .....
    .....
  - **CIC:**

Normal range	**(0-70 I.U.)**
Increased	**(71-110 I.U.)**
High	**(111-200 I.U.)**
Very high	**≥ 201**

    .....
- **Comment:** .....
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  ..... **.**

Signature: ..... **Med. Tech.:** .....**Date**: ..... /..... /.....