TESTING LAB RESULTS DATA FORM

Please Print

Please complete this form for our record data.
Send copy to BBPSP Attn: T.Soll Fax:780-401-3067
Keep original on file in Lab.

General Information

Name of Investigator: _____

Clinic/Lab Name: _____

Type of Testing: _____

Sample #	Result

All samples and results correlate and are correct.

_____ _____

Signature **Date:**

BBPSP (do not write in this area)

Date results received: _____

Date results entered into CHARMS: _____

Data Personnel signature: _____

Notes:_____

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