

Client: Example Client ABC123  
123 Test Drive  
Salt Lake City, UT 84108  
UNITED STATES

Physician: Doctor, Example

**Patient: Patient, Example**

**DOB:** 10/22/1990  
**Gender:** Female  
**Patient Identifiers:** 01234567890ABCD, 012345  
**Visit Number (FIN):** 01234567890ABCD  
**Collection Date:** 00/00/0000 00:00

**Cryofibrinogen**  
ARUP test code 0050190

Cryofibrinogen NEG 72Hour (Ref Interval: NEG 72Hour)

VERIFIED/REPORTED DATES

Procedure	Accession	Collected	Received	Verified/Reported
Cryofibrinogen	21-203-121180	00/00/0000 00:00	00/00/0000 00:00	00/00/0000 00:00

END OF CHART

H=High, L=Low, \*=Abnormal, C=Critical

Unless otherwise indicated, testing performed at: