

**PATIENT:**

Gender:	Age:	DOB:	ID:
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**ORDERING PHYSICIAN:**

Name:
Phone:

**SPECIMEN:**

Source:	Collected:
Specimen ID:	Received:
Accession ID:	Reported:

**CLIENT:**

Name:
Code:
Address:

**Helicobacter pylori Panel:**

Helicobacter pylori  
 Clarithromycin resistance determinant

**DETECTED**
**NOT DETECTED**
**COMMENTS:**