### Patient Information

- **DOB:**
- **Gender:**
- **Phone:**
- **Patient ID:**

### Specimen Information

- **Specimen:**
- **Requisition:**
- **Lab Ref #:**
- **Collected:**
- **Received:**
- **Reported:**

### Client Information

### COMMENTS:

- FASTING: NO

### Test Name

**Fecal Globin by Immunochrometry**

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<th>Test Name</th>
<th>In Range</th>
<th>Out Of Range</th>
<th>Reference Range</th>
<th>Lab</th>
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<td>TEST STATUS:</td>
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<td>SPECIMEN SOURCE:</td>
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<td>SPECIMEN QUALITY:</td>
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<td>RESULT:</td>
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### PERFORMING SITE:

UL

QUEST DIAGNOSTICS SACRAMENTO, 3714 MORTGAGE BLVD, SACRAMENTO, CA 95834-1617 Laboratory Director: M. ROSE AKIN, M.D., FCAP, CLIA: 05D0644299

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