URGENT: CRITICAL LABORATORY VALUE NOTIFICATION

Date: [Date]

Time: [Time]

To: Dr. [Physician Name]
Facility: [Clinic/Hospital Name]
Fax/Phone: [Contact Number]

Patient Information:
Name: [Patient Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]

Critical Result Details:

Test Name	Result	Reference Range	Collection Date/Time
[Test Name]	**[Critical Value]**	[Normal Range]	[Date/Time]

Action Required:
This result has been identified as a critical value that requires immediate clinical intervention. Please acknowledge receipt of this notification and initiate the appropriate medical protocol for the patient.

Laboratory Contact:
Technologist Name: [Name]
Department: [Department]
Direct Callback Number: [Phone Number]

Notice: This document contains confidential health information intended only for the use of the individual or entity named above.