Company Name
Address
Phone Number

GDX s/n _____

Test Cartridge Lot # _____
Exp. Date _____

Optics Check Lot # _____ Exp. Date _____
Range: _____

Control Lot # _____ Exp. Date _____
Level 1 Range _____
Level 2 Range _____

Cholestech G D X A1C Result Log

Sample ID #	Date	Identifier	Patient Results	Optics Check	Level 1 QC	Level 2 QC	Initials