C-Reactive Protein (CRP) Test Request Form

Patient Information

Name: John Doe

Date of Birth: 05/15/1975

Gender: Male

Medical Record Number (if applicable): 123456789

Clinical Information

Reason for CRP Test

☑ Infection

☐ Inflammatory Disease

☐ Cardiovascular Risk Assessment

☐ Other (Specify): _____

Clinical Symptoms/History

The patient presents with a high fever (102°F), productive cough, and chest pain. Suspected respiratory infection.

Provider Information

Referring Physician: Dr. Sarah Smith

Specialty: Internal Medicine

Contact Information: (555) 123-4567, dr.smith@example.com

Test Details

Test Type:

☑ Standard CRP

☐ High-Sensitivity CRP (hs-CRP)

Date of Test Request: 10/05/2023

Urgency:

☑ Routine

☐ Urgent

Additional Notes/Comments

The patient has a history of asthma and allergies. No known drug allergies. Please expedite the test due to the patient's high fever and respiratory symptoms.

Patient Consent

I hereby consent to the C-Reactive Protein (CRP) test as requested by my healthcare provider. I understand the purpose of this test and its potential implications.

Patient Signature: John Doe _____ **Date:** 10/05/2023 _____

Provider Signature: Dr. Sarah Smith _____ **Date:** 10/05/2023 _____