C-Reactive Protein (CRP) Test Request Form

Patient Information

Name:

Date of Birth:

Gender:

Medical Record Number (if applicable):

Clinical Information

Reason for CRP Test

- ☐ Infection
- ☐ Inflammatory Disease
- ☐ Cardiovascular Risk Assessment
- ☐ Other (Specify): ______________________________

Clinical Symptoms/History

Provider Information

Referring Physician:

Specialty:

Contact Information:

Test Details

Test Type:

- ☐ Standard CRP
- ☐ High-Sensitivity CRP (hs-CRP)

Date of Test Request: ____________________________

Urgency:

- ☐ Routine
- ☐ Urgent

Additional Notes/Comments

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: ______________________________ **Date:** _______________

Provider Signature: _____________________________ **Date:** _______________