C3 Complement Blood Test Requisition Form

Patient Information

- Full Name: John Doe
- Date of Birth: 01/15/1980 Gender: Male
- Contact Information: johndoe@email.com

Ordering Physician

- Physician's Name: Dr. Jane Smith
- Physician's Contact Information: (555) 789-1234

Patient History (Include relevant clinical indications)

Patient presents with joint pain, fatigue, and a history of systemic lupus erythematosus (SLE).

Insurance Information (if applicable)

- Insurance ID: 789456 Group Number: 12345
- Insurance Provider: XYZ Health Insurance

Lab Information

- Laboratory Name: Anytown Medical Lab
- Laboratory Contact Information: (555) 987-6543

Test Request

- [x] C3 Complement Blood Test
- [ ] Others: _____

Additional Instructions (if any)

Patient is fasting for 8 hours before the test.

Patient Consent and Signature:

I, the undersigned, consent to the C3 Complement Blood Test.

Signature: John Doe _____ Date: 10/12/2023 _____

Submission Instructions

Submit the completed form to the laboratory or healthcare facility responsible for collecting the blood sample. Ensure all sections are accurately filled out to expedite processing.