C3 Complement Blood Test Requisition Form

Patient Information

- Full Name: ____
- Date of Birth: ____________________ Gender: _______________
- Contact Information: ______________________

Ordering Physician

- Physician's Name: ____
- Physician's Contact Information: ________________________________

Patient History (Include relevant clinical indications)

Insurance Information (if applicable)

- Insurance ID: _____________________ Group Number: ____________
- Insurance Provider: ____

Lab Information

- Laboratory Name: ____
- Laboratory Contact Information: ______________________________

Test Request

- [ ] C3 Complement Blood Test
- [ ] Others: _______________________________________

Additional Instructions (if any)

Patient Consent and Signature:

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

Signature: _________________________ Date: _________________

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.