

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.