C-Peptide Test Requisition Form

Patient Information:

Patient Name: John Doe _____ Date of Birth: 01/15/1980

Medical Record Number: 123456789 _____ Date of Test: 10/25/2023

Gender: Male _____ Contact Information: (555) 123-4567

Referring Healthcare Provider

- Name: Dr. Jane Smith
- Clinic/Hospital Name: Smith Medical Clinic
- Phone Number: (555) 789-1234
- Email Address: dr.jane.smith@email.com

Test Details

- Date of Request: 10/20/2023
- Clinical Indication for C-Peptide Test:

  To assess pancreatic function and insulin production in a patient with uncontrolled diabetes.

- Additional Clinical Notes (if necessary):

  The patient has a history of type 2 diabetes with recent worsening of glycemic control despite treatment adjustments.

Specimen Collection

- Type of Specimen: Blood
- Collection Date and Time: 10/25/2023, 8:30 AM
- Collection Site: Right antecubital vein

Patient Consent

- I hereby consent to the C-Peptide Test as requested by my healthcare provider. I understand the purpose of this test and its implications for my diagnosis and treatment.

Patient Signature: Right antecubital vein _____ **Date:** 10/20/2023

Physician's Signature (Referring Healthcare Provider): Dr. Jane Smith

Date: 10/20/2023

Laboratory Information (for Laboratory Use Only)

- **Received By:** Lab Technician: Sarah Johnson
- **Date and Time Received:** 10/25/2023, 8:45 AM
- **Date and Time Analyzed:** 10/26/2023, 9:00 AM
- **C-Peptide Test Result:** 1.5 ng/mL
- **Comments or Interpretation (if necessary):**
  Normal C-Peptide level observed

Please send a copy of the C-Peptide Test results to the referring healthcare provider at the above contact information.