C-Peptide Test Requisition Form

Patient Information:

Patient Name:_____Date of Birth:_____

Medical Record Number:_____Date of Test:_____

Gender:_____Contact Information: _____

Referring Healthcare Provider

- Name:
- Clinic/Hospital Name:
- Phone Number:
- Email Address:

Test Details

- Date of Request: _____
- Clinical Indication for C-Peptide Test:

- Additional Clinical Notes (if necessary):

Specimen Collection

- Type of Specimen:
- Collection Date and Time:
- Collection Site:

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: _____ Date: _____

Physician's Signature (Referring Healthcare Provider): _____

Date: _____

Laboratory Information (for Laboratory Use Only)

- **Received By:**
- **Date and Time Received:**
- **Date and Time Analyzed:**
- **C-Peptide Test Result:**
- **Comments or Interpretation (if necessary):**

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