

Specimen ID:  
Control ID:

Phone:

Rte: 00



**Patient Details**

DOB:  
Age(y/m/d):  
Gender: SSN:  
Patient ID:

**Specimen Details**

Date collected:  
Date received:  
Date entered:  
Date reported:

**Physician Details**

Ordering:  
Referring:  
ID:  
NPI:

**General Comments & Additional Information**

Alternate Control Number:  
Total Volume:

Alternate Patient ID:  
Fasting:

**Ordered Items**

Complement C3, Complement C4, Serum

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Complement C4, Serum	30		mg/dL	14 - 44	01
Complement C3, Serum	133		mg/dL	82 - 167	01