



Group/Organization: _____ Location City: _____

- Employee or Member of Group Family Re-Test

COVID-19 Patient Test Request Form

Please complete this form AND provide a copy of patient insurance card and identification at the time of collection.

Form with sections: Patient Information: Completed by Patient or Guardian, Patient Clinical Information, LABORATORY TESTING - Completed by Patient, COVID 19 TESTING - Completed by Patient. Includes fields for name, address, date of birth, symptoms, and test results.

I hereby acknowledge and give full and complete consent for testing and request:

- RT-PCR COVID Oral Swab Test Anterior Nares Swab (Nostril)

I hereby acknowledge full and complete consent to and make request for a SARS-Cov2 qPCR and/or IgG. I am physically able to have this nasal swab/blood draw and have never had an adverse reaction to any phlebotomy services.

Patient/Guardian Signature: _____ DATE: _____

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