PCL PRECISION CLINICAL LAB & IMAGING

Test Requisition Form

CORONAVIRUS DISEASE (COVID 19) TESTING

Primary Patient			
LAST NAME		**FIRST NAME**	
DATE OF BIRTH (MM/DD/YYYY)		**GENETIC SEX**	
MED REC#/PATIENT IDENTIFIER		**ETHNICITY**	
ADDRESS			
CITY	**STATE/PROVINCE**	**POSTAL CODE**	**COUNTRY**
PHONE NUMBER **PASSPORT #**		**EMAIL ADDRESS**	
SAMPLE TYPE **NASAL NASOPHARYNGEAL** **OROPHARYNGEAL RNA**		**COLLECTION DATE (MM/DD/YYYY)**	
PATIENT SIGNITURE (REQUIRED FOR BILLING PURPOSES)		**DATE (MM/DD/YYYY)**	