WREN Laboratories

COVID-19 TESTING REQUISITION

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FORMS MUST BE FULLY COMPLETED
INCOMPLETE FORMS WILL DELAY SAMPLE

About you

Please use BLOCK CAPITALS throughout this document

Last Name | First Name | Other Initials

Date of Birth (M M D D Y Y) | Gender (X Male X Female X Other) | Occupation

Street Address | Apartment/Building/Floor | Zip Code

City | County | State

Phone Number | Email Address

Race

- X American Indian or Alaska Native
- X Asian
- X Black or African American
- X Native Hawaiian or Pacific Islander
- X White
- X Other Race
- X Unknown

Ethnicity

- X Hispanic or Latino
- X Non-Hispanic or not Latino
- X Unknown

Payment information

Indicate party to invoice or provide credit card details

Name of Institute | Phone Number

Email Address

Address | Zip Code

Credit Card Type | Credit Card Number | Expiry Date (M M Y Y)

For the most up to date information on COVID-19 please visit the CDC Coronavirus Disease 2019 (COVID-19) webpage: www.cdc.gov/COVID19

Requisitioners information

You must include Requisitioners Name and Facility

Requisitioners Full Name (your healthcare provider, employer or you if neither applicable)

NPI Number (if applicable)

Facility (your healthcare provider, employer or leave blank if neither applicable)

Phone Number

Requisitioners Address

Zip Code

Email Address

How would you like to receive the report

Report Send Out

- X Requisitioners Email
- X Requisitioners Address
- X Fax
- X Patients Email
- X Patients Address

Fax Number

Please indicate reason(s) for the COVID19 Test

You must tick at least one box

- X Patient has signs and symptoms (e.g. fever, cough, difficulty breathing)
- X Patient lives in or has recently traveled to a place where transmission of COVID-19 is known to occur
- X Patient has been in close contact with an individual suspected of, or confirmed to have COVID-19
- X Workplace safety

Please check if applicable

- X Patient works in a healthcare setting
- X Patient is pregnant (if female)
- X This is the patients' first test for COVID-19
- X Patient resides in a congregate setting

Please check if patient is symptomatic

- X Patient works in a healthcare setting
- X Patient is pregnant (if female)

Requisitioners signature

By signing below, I have obtained the necessary authorization for COVID-19 testing as required by State and Federal Law.

Requisitioners Signature

Date M M D D Y Y

Patient/Authorized Signature

Date M M D D Y Y