COVID-19 PCR Test Lab Request Form

Patient Information

Full Name:

Date of Birth:

Gender:

Identification Number:

Contact Number:

Email Address:

Address:

Test Request Details

Sample Collection Date:

Sample Type:

Reason for Test:

Clinical Information

Symptoms	Date of Onset	Comments

Exposure History:

Physician Information

Physician Name:

Contact Number:

Physician Email:

Hospital / Clinic:

Physician's Signature & Date

Lab Staff Receiving Sample