WAKE TOXICOLOGY
Confidence In Testing

WAKE TOXICOLOGY LABORATORY LLC

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COVID-19 Test Requisition Form

CLIA#: 34D2150941

Patient Information *Required Information

Last Name*	**First Name***	**Middle Initial**	**Suffix**
Date of Birth* (MM/DD/YYYY)	**Sex*** ☐ **Male** ☐ **Female** ☐ **Other**	**Race/Ethnicity**	
Address	**City***	**State***	**ZIP**
Email*	**Phone Number***		

Submitter Information **Insurance Information**

Hospital, Laboratory, or other Facility*		**Insurance Name**
Health Care Provider	Name	**Insurance ID**
Address (include room)*		**Group No**
Primary Contact (If not the Health Care Provider)	Name	

** Final report will be sent to the mobile or email

Specimen Information

Date of Collection* (MM/DD/YYYY):	Time of Collection*:
Patient Signature	

Reason for Submission* ☐ Sickness ☐ Contracted with COVID positive person ☐ Diagnostic

Specimen Type (check all that apply)* ☐ Aptima Specimen Transfer Tube (Green Label) ☐ Swab ☐ UTM ☐ VTM ☐ Aptima Multitest Specimen Tube (Orange Label) ☐ Sterile Container ☐ Blood Tube (Plasma, Serum or Whole Blood) ☐ Other (specify)

Specimen Source*

☐ **Nasopharyngeal (NP)** ☐ **Nasal** ☐ **Oropharyngeal (OP)**
☐ **Other (specify)** ☐ **Throat**

Test Request

☐ **SARS CoV-2 Molecular Test (RT-PCR)**

Clinical Symptoms

Has the patient experienced any symptoms? ☐ Yes ☐ No	Earliest Symptom Onset Date?
If the patient has experienced symptoms, please check all that apply:	
☐ Fever	☐ Cough
☐ Shortness of breath/difficulty breathing	☐ Muscle Pain
☐ Chills	☐ Headache
☐ Repeated shaking with chills	☐ Sore Throat
☐ New Loss of Taste or Smell	☐ Altered Mental Status/ Disoriented/ Confusion
☐ Fatigue/Tiredness	☐ Gastrointestinal (e.g nausea, vomiting, diarrhea)
☐Other	