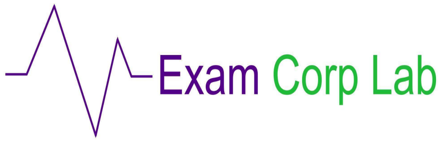
DATE:________________



9024 N. Milwaukee Ave. Niles, IL. 60714
Tel: 847 391-9881 Fax: 847 391-9886

COVID – 19
LAB REQUISITION

PATIENT INFORMATION

LAST NAME

FIRST NAME

M F

BIRTHDATE

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE/EMAIL

COUNTRY:

PASSPORT #

SERVICE REQUEST TYPE

COVID-19 PCR TEST

COVID-19 RAPID ANTIGEN TEST

VACCINE VERIFICATION

ADDITIONAL PEOPLE IN PARTY, PLEASE LIST (IF NONE, N/A)

TEST INFORMATION

DATE REQUESTED/ TIME COLLECTED

Location of Specimen Collection: ___________________________

AUTHORIZATION & PAYMENT INSTRUCTIONS: I permit the copy of this authorization be used as the original. I agree to be personally responsible for payment of the laboratory services and specimen collection.

Patient Signature: _____________________________________