COVID-19 TESTING REQUISITION

688 East Main Street, Branford, CT 06405
Phone: 203 2083464 Email: info@wrenlaboratories.com

FORMS MUST BE FULLY COMPLETED
INCOMPLETE FORMS WILL DELAY SAMPLE

To complete this form online and print please visit: wrencovidtesting.com/start
Once completed print out, sign and return with the saliva specimen.

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 Native Hawaiian or Pacific Islander

X Unknown

X Asian

X White

X Black or African American

X Other Race

Ethnicity

X Hispanic or Latino

X Non-Hispanic or not Latino

X Unknown

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)
- M M D D Y Y Date of onset of symptoms
- X Patient lives in or has recently traveled to a place where transmission of COVID-19 is known to occur
- X Workplace safety
- X Patient has been in close contact with an individual suspected of, or confirmed to have COVID-19

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 has been hospitalized
- X Patient has been admitted to ICU

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

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