



Group/Organization: St Paul the Apostle School # 1738

Location City: Los Angeles

- Employee or Member of Group, Family, Re-Test

COVID-19 Patient Test Request Form

Please complete this form AND provide a copy of patient insurance card and identification at the time of collection.

Form with sections: Patient Information, Patient Clinical Information, LABORATORY TESTING - Completed by Patient, COVID 19 TESTING - Completed by Patient

I hereby acknowledge and give full and complete consent for testing and request:

- RT-PCR COVID Swab Test, SARS-Cov2 IgG Antibody Test, SARS-Cov2 IgM Antibody Test

SOURCE of RT-PCR Swab Test: Anterior Nares Swab (Nostril), Nasopharyngeal Swab (Nasal), Oropharyngeal Swab (Mouth)

I hereby acknowledge full and complete consent to and make request for a SARS-Cov2 qPCR and/or IgG. I am physically able to have this nasal swab/blood draw and have never had an adverse reaction to any phlebotomy services.

Patient/Guardian Signature: DATE: