The Saratoga Hospital

Laboratory Test Requisition for COVID-19

Order Date & Time: _____

Patient First Name: _____

Patient Last Name: _____

Patient Date of Birth: _____

Patient Phone Number: _____

_____ _____ _____/_____

Name of Ordering Provider (print name) Ordering Provider (signature) Date/Time

OR

_____ _____ _____/_____

RN Taking Telephone Order (print name) RN (signature) Date/Time

Diagnosis Codes: _____

1. Fill out this Laboratory Requisition.
2. Fax to the Patient Access Department (518) 580-2134.
3. Patient Access will contact patient to set up an appointment to come in for collection.

☐ **COVID-19 Virus PCR Send Out Test**