UK HealthCare Hospitals & Clinics
800 Rose Street
Lexington, KY 40536

Section Completed by UK HealthCare Scheduler

Please attach patient demographic face sheet

Ordering Physician: _____ **Scheduler:** _____

Scheduler Phone: _____ **Fax Results to:** 859-257-0147

Patient Demographics:

7124412 Place patient demographic label here or hand-write the two patient identifiers 7124412

Patient Name: _____

UK MRN: _____

Date of Birth: _____

SS#: _____

Sex: ◯ Male ◯ Female

Test Requested:

☑	**COVID**	SARS CoV2/COVID 19 by PCR	**Source:** ◯ Nasopharyngeal swab ◯ Oropharyngeal swab **Transport Media:** ◯ Saline ◯ UTM ◯ VTM **Special Instructions:** Fax results upon completion of testing

Collector: Please denote source & transport media

Diagnosis: Screening for procedure

Collection Date:

Collection Time:

Physician Signature:

Please fax results upon completion of testing to 859-257-0147