



UK HealthCare Hospitals & Clinics

800 Rose Street
Lexington, KY 40536

Section Completed by UK HealthCare Scheduler

Please attach patient demographic face sheet

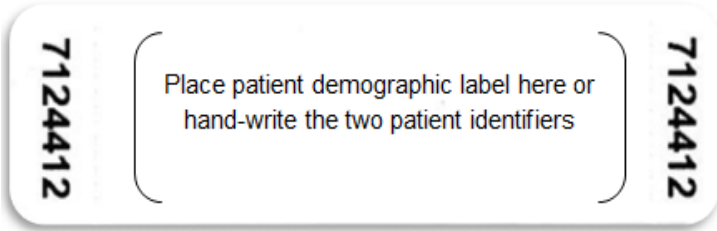
Ordering Physician: _____

Scheduler: _____

Scheduler Phone: _____

Fax Results to: 859-257-0147

Patient Demographics:



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