ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE

Clinical Immunology Laboratory Requisition Form

Website: rfuclinlab.net

3333 Green Bay Road
Room 2.232
North Chicago, IL 60064
Tel: 847-578-3444
Fax: 847-775-6506
E-mail: clinlab@rosalindfranklin.edu

REFERRING PHYSICIAN INFORMATION: PLEASE PRINT

NAME		ADDRESS	CITY/STATE
Kathy Salinger		555 No. Sheridan Rd.	Lake Forest, IL
NPI#	E-MAIL	PHONE	FAX
1295014892	salinger@mx.lakeforest.edu	847 735-5240	847 735-6098

PATIENT INFORMATION: (Highlighted section MUST be completely filled out)

LAST NAME	FIRST NAME	MIDDLE INITIAL	PATIENT PHONE#

ADDRESS	CITY	STATE	ZIP
		IL	

DATE OF BIRTH (DD/MM/YY)	☐ MALE ☐ FEMALE	ETHNICITY	RACE	COLLECTION DATE (Entered by staff)	TIME (staff only)	☐ AM ☐ PM

PAYMENT OR INSURANCE INFORMATION: Billing: ■ Client ☐ Patient ☐ Insurance

Select test/tests:

■ **COVID-19 (SARS CoV-2) RNA, QUALITATIVE RT-PCR**

☐ **COVID-19 SEROLOGY, IgG ANTIBODY**

For RNA test indicate the type of submitted specimen:

Upper respiratory tract specimen, swab: ☐ Nasopharyngeal ☐ Nasal (mid-turbinate or anterior nares) ☐ Oropharyngeal

Lower respiratory tract specimen: ☐ Saliva