TEST REQUISITION FORM

TOMORROW'S HEALTH
4309 W 27th Place, Suite 201
Kennewick, WA 99338
509-943-2174 (Office) | 509-940-0285 (Fax)
www.tomorrowshealth.net

Patient ID/Accession Number

FOR LABORATORY USE ONLY:

Specimen Received:
❑ NP Swab ❑ Serum ❑ Plasma ❑ Whole Blood
❑ Saliva ❑ Urine ❑ Other Source _____
Collection Fee: ❑ $10 Saliva Specimen Fee: ❑ $5

Date Received:_____ Time____:_____ am/pm By:_____
Date Collected:_____ Time____:_____ am/pm By:_____

1) PATIENT INFORMATION:

Patient Name: Last Name First Name Middle Initial
Address: Street City State Zip
Date of Birth: Sex: Cell Phone #:

Race: Choose... Ethnicity: Choose...

2) BILLING INFORMATION:

☐ Insurance Billing:
Insurance Company Name:
Insurance Company Address:
Group Number: Member ID:
Patient relation to policy holder: Dependent
Policy holder name (as listed): D.O.B.

☐ Self-Pay (Due at time of service): Cash or Card

*I acknowledge that insurance may not reimburse the cost of testing. Patient Initials

☐ Client Bill:
Client Name
Client Contact Number:

3) ORDERING CLINICIAN:

Ordering Clinician: Type/Print Name
Company Name: Clinician Signature _____
Address: Email:
Phone # Fax #:
Physician ID#: NPI#:
Test Results: ❑ Fax ❑ Email ❑ Electronic ❑ Mail/Hardcopy

4) LABORATORY TEST ORDER:

COVID-19 Testing:
☐ SARS-COV-2 by RT-PCR (Individual)
☐ SARS-COV-2 by RT-PCR (Pooled)*
☐ SARS-COV-2 Rapid Antibody (IgM, IgG)

* For information, see COVID-19 test information page

Other Laboratory Testing:
Choose a test Choose a Test...
Choose a test Choose a Test...
Choose a test Choose a Test...
Choose a test Choose a Test...
Choose a test Choose a Test...

Name:_____ Name:_____ Name:_____ Name:_____

DOB:_____ DOB:_____ DOB:_____ DOB:_____