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| **Requisition for Ambulatory Patient Tent**  **Only to be used for non- epic affiliated providers**  **Fax this requisition to Marlborough lab at fax number:**  **508-229-1240** | | | |
| **Patient Last Name, First Name** | | | |
| **Address:** | | | |
| **Insurance Company and Number:**  **Guarantor:** | | | |
| **Date of Birth: Sample Collection Date:** | | | |
| **MRN: Fax Number:** | | | |
| **Direct Phone for Provider:** | | | |
| **Must provide DX code: Ordering Provider:** | | | |
|  |  |  |  |
|  | **TEST** | **MNEMONIC** | **SPEC TYPE** |
| **X** | **COVID -19PCR (QUEST) QML-39433** | **LAB31809** | **NP SWAB** |
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