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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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