Testing Request Form

Testing available for Sarasota County residents

Fax this completed form to 941-554-5502

Health Care Provider Information:

Physician name: _____ Physician UPIN: _____

Practice name: _____

Phone number: _____ Fax Number: _____

Email address: _____

Office street address: _____

City: _____ State: _____ Zip Code: _____

Practice type: ☐ Independent practice ☐ Group practice

☐ Urgent Care Center ☐ Hospital ☐ Other _____

Patient Information:

Patient Last Name: _____ First Name: _____ MI: ____

DOB (MM/DD/YYYY): _____ Patient Phone Number: _____

Sex: ☐ Male ☐ Female Race: _____ Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____

Patient is currently ill and has been screened and meets current CDC testing criteria. Visit https://www.cdc.gov/ for latest guidance.

Date of Onset: _____

Check all applicable criteria/symptoms below:

☐ Fever ☐ Cough ☐ Shortness of breath

☐ Close contact with a laboratory confirmed COVID-19 case

☐ **Recent** International Travel

☐ **Recent** Domestic travel to an area where COVID-19 is prevalent