



TEST REQUISITION FORM - COVID 19 ANTIBODY TESTING

PATIENT DEMOGRAPHICS:		CLIENT DETAILS:	
Patient Name:		CC Code:	
Patient Address:		CC Name:	
Contact No:		REFERRING DOCTOR DETAILS:	
E-Mail ID:		Name:	
Date of Birth:		Code:	
Male Female Others		SPECIMEN INFORMATION:	
Heightkg TEST DETAILS:			DD/MM/YY
		•	AM/PM
Test Code	Test Description		AM/ F/W
	·		EMPERATURE RECEIVED:
SPECIMEN TYPE	Plasma EDTA/FL/CIT/ACD	Ambient: 25±5°C	Ambient: 25±5°C
Serum		Refrigerated: 2-8°C	Refrigerated: 2-8°C
		Frozen: -10 to -30°C	Frozen: -10 to -30°C
	elines please note the possible groups/com ing ELISA/ CLIA test (please tick appropriate		ecific requirement for
A) Immunocompromised patients		K) Drivers/Cleaners and Helping staff	
B) Individuals in containment zone		L) Banks, post, couriers, telecom offices	
C) Healthcare workers		M) Air travel related staff	
D) Security personnel		N) International operations	
E) Police and paramilitary personnel civil defense & volunteers		O) Congregate settings	
F) Press corps		P) Prisons	
G) Rural, tribal population (after reverse migration)		Q) Plasma therapy candidate	
H) Industrial workers or Labour force		R) Shops: Vendors and/or owners as well as staff working in shops	
I) Farmers, vendors visiting large markets		for essential goods, groceries, vegetables, milk, bread, chemists	
J) Staff in municipal bodies		working at pharmacies, eateries and take away restaurants, etc.	
	d that COVID Antibody testing has no dia scribed this test by my doctor and wish to		urposes of sero surveillance only.
Dated Signature/Thumb Impression of Patient		Dated Signature/Thumb Impression of Requisitioner	
	to provide all the requested information to enable accurate locument, I agree to receive promotional messages, e-mail		