Date of Request _____ CSN Number: _____

Chart #: _____ Location _____

Patient Name _____

Date of Birth _____

Ordering Provider _____

BASSETT HEALTHCARE NETWORK
1 Atwell Rd
Cooperstown, NY 13326
Phone: (607)547-3975
Fax: (607)547-6717

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

LAB1851 COVID-19 (Abbott ID NOW)

SOURCE: ___Nasal _____

Pre-procedure: Collect & Hold

Procedure: Date:_____

Time:_____

Location:_____

Or Place Preop Label in this section

Provider's Signature:_____

Signed Date and Time:_____

Received by: _____