

Oklahoma State University Diagnostic Laboratory*

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CLIA #: 37D2180955

Please, PRINT; *indicates required fields

Patient Information			
Name* (last)	(first)		(initial)
DOB*/			
Address*			
City* State*	Zip*Patient Medic (optional):	al Record Number	
Sex:* □M □F			
(mark all applicable) Ethnicity: □Hispanic/Latino Race: □White □American Indian/Alaska Native	□Non-Hispanic/Non-Latino □Black/African American □Native Hawaiian/Other Pacific	□Unkno □Asian Islander □Other	
Submitter Information Practitioner Name* (last)	(first)		(initial)
NPI Facility Name*			
Phone # () - Fax # () Address*	*Include the fax numb if email is not available to receiving results.	er in which you would like e. Please note this may add a	
City* State Zip*			
Email* (results will be sent via encrypted email	to this address):		
Clinical Information Diagnosis / / / Antibiotics (list and start dates)			
Specimen Information Collection Date (mm-dd-yyy)* / / / / Source/Type*(check one only) **Specimens mus	_ Time <i>(hour:minute)</i> t be kept between 2-8° C from col		
□ Blood □ Serum □ Urine □ Stool □ Sputum, expect. □ Sputum, induced □ Bronch	☐ CSF ☐ Pleural fluid	☐ Pericardial fluid☐ Bronchoalveolar lavage☐ Vagina	☐ Blood smears
Test Request			

Test Request