



# POLYMERASE CHAIN REACTION (RT-PCR) TEST REQUEST FORM

## PATIENT INFORMATION:

NAME: (Last) ..... (First) ..... (Middle Initial) .....

SEX: Male [ ] Female [ ] DOB (DD/MM/YYYY): .....

Address: ..... Parish: ..... Phone: .....

Nationality: ..... Email Address: .....

## TRAVEL DETAILS:

Airline & Flight #: ..... Departure Date & Time (DD/MM/YYYY): .....

Destination: .....

## PRE-OPERATIVE REQUIREMENT:

Proposed Surgery Date: (DD/MM/YYYY): ..... Surgeon: .....

### Application Requirements:

- Completed PCR test request form for each person
- Government issued photo ID (*passport preferred*)
- Processing Fee

### Swabbing Requirements:

- Please email a copy of your travel itinerary and this stamped PCR request form to [covidresults@msjmc.org](mailto:covidresults@msjmc.org) for an appointment.
- Original PCR test request form stamped by MSJMC Cashier & Passport must be presented to the physician at the time for testing.

## FOR OFFICIAL USE ONLY:

MPI#: .....

Account #: .....

Receipt #: .....

Swab Collection Date: .....  
(DD/MM/YYYY)

Hospitalization: Yes [ ] No [ ]

Pre-Op: Yes [ ] No [ ]

Travelling: Yes [ ] No [ ]

Other: \_\_\_\_\_

Cashier Stamp, Signature & Date:

Physician Stamp, Signature & Date: