2600 Glasgow Ave #108
Newark, DE 19702

Patient information:

Last Name:---------- First Name:----------

Date Of Birth:---------- Gender: M F

Address:---------- City/State/ZipCode:----------

Phone #:----------

QUICKVUE SARS ANTIGEN TEST (COVID 19 RAPID TEST)

I understand and give permission to Glasgow Pharmacy to test for Covid 19. I understand that the services provided may not be covered by insurance. I fully understand that I am responsible for the payment.

Patient Signature:----------

For Pharmacy Staff:

Specimen Collection Information:

Collection Date: -----/----/----- Collection Time:----------