NKGen Biotech, Inc.
3001 Daimler St., Santa Ana, CA 92705
Laboratory Medical Director: Basel Kashlan, MD
CAP: 7541687   CLIA:05D2027259
Client Services Contact Information
Phone: 949-396-6830   Fax: 949-861-9565
Email: NKMClientServices@nkgenbiotech.com

Laboratory Requisition

Patient Information

Print Name *(Required)*

_____

Last   *First*   *MI*

Date of Birth *(Required)*

_____

MM/DD/YYYY

Address

_____

Street

_____

City, State, Zip Code

Phone Number

_____

Sex *(Check one):*

❑ Male   ❑ Female

❑ Decline to answer

ICD-10 Code:

_____

COVID-19 Test Data Report Requirement

Patient who receives COVID 19 test (e.g. molecular or antibody) from NKGen clinical laboratory would require to submit information using the on-line assessment form.

COVID 19 Lab Test Order Patient Assessment

Click Here For Link

QR code for use on your smartphone

As required by Coronavirus Aid, Relief, and Economic Security (CARES) Act Section 18115, clinical laboratories and testing providers that perform diagnostic testing under a Clinical Laboratory Improvement Amendments (CLIA) certificate to report the results of any test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19

Physician/Client Information

Physician Name   **NPI Number**

_____   _____

Institution/Facility/Office Name

_____

Address

_____

Phone Number   **Fax Number**

_____   _____

Tests Requested

❑ **SalivaDirect™ - COVID-19 Test** (Qualitative Real-Time RT-PCR test for detection of nucleic acid from SARS-CoV-2 - EUA)

Specimen Collection

1) Specimen Type (Check One):

❑ Saliva

2) Specimen Collection

Collection Date: _____

Collection Time: _____

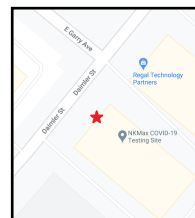Collected By: _____

Specimen Drop Off Instructions

1) Prior to drop off, store specimen at room temperature (≤ 25°C).

2) Please drop off specimen to the NKMax collection window located at the front of the building.

NKGen Biotech , Inc.
Address: 3001 Daimler St, Santa Ana, CA 92705
Hours: 8:00 AM - 5:30 PM
Phone: (949) 396 - 6830

Physician Signature

_____   X _____   _____

Ordering Physician Name   *Ordering Physician or Authorized Designee Signature*   *Date (MM/DD/YY)*

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