



COVID-19 ANTIBODIES ASSAY SUBMISSION FORM

601 Biotech Drive, Suite 301
North Chesterfield, VA 23235
PHONE: (844)947-2643; FAX: (804)977-5041
Email: clientservices@grangergenetics.com

PATIENT INFORMATION

Last Name\* First Name\* MI
DOB\*: SEX (M / F): MRN # / Sample ID:
Street Address City, State, Zip Code

INSTITUTIONAL BILLING INFORMATION

Institution Name:
PO# if Required:
Billing Address:
Phone: Fax:
Email:

PATIENT PAY INFORMATION

Name on Card:
Card Number:
Expiration Date: CVV:
Billing Address:
Signature:
By signing this form, you authorize Granger Genetics to charge your card \$139.00.

SAMPLE INFORMATION

Date of Collection\*:
Did the patient have a previous PCR test performed for COVID-19\*? YES NO
If Yes, Date test was performed\*: PCR test results\*: POSITIVE NEGATIVE

\*Indicates Required Field
\*\*See sample submission requirements on the back of the page

RESULTS\*

Fax Results to:
Mail Results to:

SAMPLE TUBE LABEL AND COMMENTS



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**\*\* SPECIMEN REQUIREMENTS**

**Specimen:** Serum

**Collection:** Venous Collection, Red-top tube or gel-barrier tube, separate serum from RBCs within 2 hours,  
Freeze/Refrigerate serum immediately

**Volume:** 0.5 – 2 mL

**Storage Instructions:** Freeze prior to transport

**Please Note:** Granger Genetics is closed Saturday and Sunday. Serum Samples should be shipped cold by overnight express for delivery Monday through Friday.