

Health and Environment Testing Laboratory SARS-CoV-2 Specimen Submission Form

This form **must be submitted** with SARS-CoV-2 test requests. Specimens that are submitted for SARS-CoV-2 testing without this form or with incomplete information may be delayed or not tested. rev. 10/2/2020

Facility Information

Facility: Ordering Provider Name:
Contact Person: Telephone:
Address: OR
Telephone: Test conducted using DHHS Standing Order, Dr. Siiri Bennett MD
Secure Fax#:

Patient Information

Patient Name (Last, First, MI)

DOB: __ / __ / ____ (mm/dd/yyyy)

Patient Address

Patient Gender: Male Female Other
Patient Phone Number:

Patient preferred language, if not English:

Please specify

Race: White
 American Indian or Alaskan Native
 Black or African American
 Asian
 Native Hawaiian/Pacific Islander
 Other
 Two or more races

Ethnicity: Hispanic or Latinx
 Non-Hispanic

Special Conditions: Please indicate if any of the following conditions exist:

Hospitalized	<input type="checkbox"/> yes	<input type="checkbox"/> no	Facility name _____
Health Care Worker:	yes	<input type="checkbox"/> no	Facility name _____
First Responder (Police, Fire, EMS):	<input type="checkbox"/> yes	<input type="checkbox"/> no	Organization _____
Congregate Setting (LTC, Jail, shelter, farm, etc)	<input type="checkbox"/> yes	<input type="checkbox"/> no	Facility name _____
Patients older than 60 years	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Pregnant	<input type="checkbox"/> yes	<input type="checkbox"/> no	

Clinical Information

Symptomatic (please indicate x, below) OR **Asymptomatic**

<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath or difficulty breathing
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Muscle or body aches	<input type="checkbox"/> New loss of taste or smell
<input type="checkbox"/> Headache	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Congestion or runny nose
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Diarrhea	

Date of symptom onset: __ / __ / ____ (mm/dd/yyyy)

Patient with underlying medical conditions? Yes (please specify)

No

Specimen Collection Information

Supervised onsite self-collection (Nasal mid-turbinate)
 Supervised onsite self-collection (Anterior Nares)

CLINICIAN COLLECTED – Check source below

<input type="checkbox"/> Nasopharyngeal
<input type="checkbox"/> Oropharyngeal (Throat)
<input type="checkbox"/> Anterior Nares (nasal swab)
<input type="checkbox"/> Nasal mid-turbinate (nasal swab)
<input type="checkbox"/> Other (_____) please specify

FOR ANY SPECIMEN TYPE:

Date of Specimen Collection __ / __ / ____ (mm/dd/yyyy)