

COVID-19 Test Request Form

Patient Information (** Required fields)					
Last Name**		First Name**		Middle initial	
Address**		Phone Number			
City**		State**	Zip**	County of Residence**	
DOB (MM/DD/YY)**	Sex**	Race**			
	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> White <input type="checkbox"/> American Indian/Native Alaska <input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Other	
Ethnicity**			Other Questions**		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			Contact with a confirmed case of COVID? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Symptoms** (Mark all that apply)			Health Care Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Date of Onset (MM/DD/YY):			Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle aches <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> New loss of taste <input type="checkbox"/> New loss of smell <input type="checkbox"/> None/Asymptomatic <input type="checkbox"/> Other, specify _____			Was other testing performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
			If Yes, indicate test and result _____		
			Patient has underlying medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Submitter Information (** Required fields)			
Submitter ID or #** (if you do not have one, leave blank)		Submitter's/Facility's Name**	
Submitter's/Facility's Address**		City**	State**
			Zip**
Contact Person**	Phone Number**	Fax Number**	Email**

Test Requisition Information(**Required fields)		
Date Collected**	Time Collected**	Purpose**
		<input type="checkbox"/> Pre-surgery/Pre-operation Screen <input type="checkbox"/> Suspected Outbreak <input type="checkbox"/> Other, specify _____
Specimen Type**		Requestor Information** (Must be a licensed medical practitioner)
<input type="checkbox"/> Nasal Swab <input type="checkbox"/> Nasopharyngeal Swab (NP) <input type="checkbox"/> Oropharyngeal Swab (OP) <input type="checkbox"/> Nasopharyngeal and Oropharyngeal Swab (NP & OP)		Requestor's name: _____
		Requestor's phone number: _____

Fill out this form in its entirety. All fields are required. Type and print a completed form with each specimen.