



Place Barcode label here

**Primary SUBMITTER INFORMATION\* - Please Print Legibly**

(Fill out this section as the facility or healthcare provider submitting the specimen)

Submitter Facility Code: \_\_\_\_\_  
 Submitter Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
 Physician (Full Name): \_\_\_\_\_

*\*Note: The laboratory cannot give results out to another healthcare provider without consent from the primary submitter. See next column to add secondary submitter information.*

**PATIENT INFORMATION - Please Print Legibly**

NOTE: All specimens MUST be labeled with Date of Birth and Date of Collection

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Patient ID #: \_\_\_\_\_  
 D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
 MM/DD/YY  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 County: \_\_\_\_\_ Patient Tel #: \_\_\_\_\_

**RACE (Circle One):** WHITE BLACK ASIAN NATIVE - American/Alaskan  
 MULTIRACIAL HAWAIIAN/PACIFIC ISLANDER UNKNOWN OTHER \_\_\_\_\_

**ETHNICITY (Circle One):** NON-HISPANIC HISPANIC UNKNOWN

**SPECIMEN INFORMATION:** (Must fill out or testing will be delayed)

DATE of collection: \_\_\_\_\_

TIME of collection: \_\_\_\_\_

MATRIX:  
 VTM  
 SALINE  
 OTHER: \_\_\_\_\_

**SITE/SOURCE of Specimen (please check):**

Swab type:	Other type:
<input type="checkbox"/> Anterior Nares (Nasal)	<input type="checkbox"/> Sputum
<input type="checkbox"/> Mid-Turbinate	<input type="checkbox"/> Tissue (Specify) _____
<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Fluid (Specify) _____
<input type="checkbox"/> Oropharyngeal	<input type="checkbox"/> Other (Specify) _____

**Secondary SUBMITTER INFORMATION - Please Print Legibly**

(Fill out this section if results need to be reported to another facility or healthcare provider)

Submitter Facility Code: \_\_\_\_\_  
 Submitter Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
 Physician (Full Name): \_\_\_\_\_

If testing occurred at a State sponsored site, indicate location:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Additional patient information requested:**

**Check if patient is:**

- Healthcare Worker
- Inpatient - (Circle one: ER ICU Regular bed Unknown)
- Emergency Responder
- Long Term Care Facility Resident (LTCF)
- LTCF Resident Testing/Surveillance Program
- LTCF Staff Testing
- Work at a Facility or Business with an Outbreak
- Correctional Facility Staff or Inmate
- Pregnant
- Homeless
- Resident - (Circle one: Group Home Setting or Foster care)
- Resident - Other not listed above: \_\_\_\_\_

**Patient Symptoms:**

- Patient is Symptomatic
- Patient is Asymptomatic<sup>†</sup> (if selected, answer questions below)

<sup>†</sup>If patient is asymptomatic:

- a. Did patient have direct exposure to a confirmed case of COVID-19?  Yes  No
- b. Date of exposure: \_\_\_\_\_ (can be approximate date) (If no to the question above, skip to c.)
- c. Did patient request testing without any known risk factors?  Yes  No
- d. Does patient have any other reason to request testing?  
 \_\_\_\_\_

**COMMENTS:**

**PHL USE ONLY:**