



COVID-19 SARS-CoV2 TEST REQUISITION

http://www.dhhs.nh.gov/dphs/lab/documents/labrequisition.pdf

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.*

HAS THIS SAMPLE BEEN REQUESTED BY THE NH STATE PUBLIC HEALTH DEPT? Y N

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: <input type="checkbox"/> VTM <input type="checkbox"/> SALINE <input type="checkbox"/> OTHER: _____

Swab type: _____ Other type: _____
 Anterior Nares (Nasal) Sputum
 Mid-Turbinate Tissue (Specify) _____
 Nasopharyngeal Fluid (Specify) _____
 Oropharyngeal Other (Specify) _____

Secondary SUBMITTER INFORMATION - Please Print Legibly

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

Secondary Submitter Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Telephone No.: _____ Fax No.: _____
 Physician (Full Name): _____

CHECK APPROPRIATE TEST REQUEST:

SARS-CoV2 PCR (if positive, may reflex to variant testing)

VARIANT SEQUENCING ONLY**

Test Method: _____ CT Value: _____

**For epidemiological purposes only. No reports will be issued to submitter.

Additional patient information requested:

Check if patient is/has:

- Traveled Domestically in the past 14 days
Location & dates of travel: _____
- Traveled Internationally in the past 14 days
Location & dates of travel: _____
- Previously diagnosed with COVID-19 in the past 90 days,
but concern for re-infection
- Fully vaccinated against COVID-19, but concern for new infection
- 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 Asymptomatic¹ (if selected, answer questions below)
- ¹If 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)

COMMENTS:

PHL USE ONLY