



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[†] (if selected, answer questions below)

[†]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 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: