COVID-19 Testing Request Form

(Print using upper case letters)

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LAB USE ONLY

Specimen Number Area Below

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S LAST NAME

BIRTHDATE / /

PATIENT'S IDENTIFICATION NUMBER

PREGNANT
○ Yes ○ No ○ UNK

RACE
○ White ○ Asian/Pacific Islander
○ African American/Black ○ Other
○ Native American ○ Unknown

ETHNICITY
○ Hispanic
○ Non-Hispanic

SEX
○ Male
○ Female

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

PHONE NUMBER - -

TEST INFORMATION

DATE COLLECTED / /

TIME COLLECTED :

SYMPTOM ONSET DATE / /

ONLY ONE (1) SAMPLE PER FORM

SPECIMEN SOURCE TYPE

○ Nasopharyngeal Swab ○ Nasal Swab

○ Pharyngeal Swab ○ Oropharyngeal Swab

1CD-10 CODE

○ R05 Cough ○ R50.9 Fever

○ R06.02 Shortness of Breath ○ Z20.828 Contact with and suspected exposure to viral communitable disease

○ Other

SUBMITTER INFORMATION

SUBMITTER PHONE NUMBER - -

FAX NUMBER FOR REPORTING RESULT* - - -

FAX REQUESTED
○ Yes ○ No

SUBMITTER'S NAME

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

CONTACT PERSON

PHYSICIAN NAME

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