Lab Use Only

Date received: ____/____/____
Rejection Criteria:
- ❑ Inappropriate temperature
- ❑ Sample >72 hours from collection
- ❑ Incomplete labelling
- ❑ Incorrect specimen type

COVID-19 Test

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name				
First Name	MI			
Address/Attention:				
Street Address:				
City:	State:	Zip:	County:	County Code:
Phone Number:			Date of Birth: ____/____/____	
Medical Record Number:			Medicaid Number (if applicable):	

Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown

Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Isle ❑ Unknown

Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Diagnosis Code(s) ICD-10 Reason for Encounter/Visit:

- ❑ Encounter for Screening COVID-19 (U0001)
- ❑ Other Code: _____

Prioritized Group:

- ❑ Hospitalized Patient
- ❑ Healthcare Professional or First Responder
- ❑ Live in/Contact with High-Risk Setting/Congregate living facility
- ❑ Higher Risk of Severe Illness
- ❑ Uninsured
- ❑ Post-mortem specimens

Alternate Group:

- ❑ ILINet Surveillance+

+ *Will be tested for both COVID-19 and Influenza. Answer the following for ILINet specimens:*
Flu vaccination in past year? Yes ❑ No ❑ Unsure ❑
Recent travel history? Yes ❑ No ❑ Unsure ❑

- ❑ Other* _____

** Includes people who attended protests, rallies, mass gatherings, study participants, or other emerging groups*

Patient History

ICU Patient? Yes ❑ No ❑ Unsure ❑
First test? Yes ❑ No ❑ Unsure ❑
Pregnant? Yes ❑ No ❑ Unsure ❑
Symptomatic? Yes ❑ No ❑ Unsure ❑

Symptom onset date, if symptomatic? _____/_____/_____

Check any symptoms that apply: ❑ Fever over 100.4F ❑ Feeling feverish ❑ Chills ❑ Cough ❑ Shortness of breath ❑ Difficulty breathing ❑ Fatigue ❑ Headache ❑ Muscle or body aches ❑ New loss of taste ❑ New loss of smell ❑ Sore throat ❑ Nasal congestion ❑ Runny nose ❑ Nausea ❑ Vomiting ❑ Diarrhea

The provider listed below certifies all information is correct and all questions answered to the best of their ability. _____ Provider Initials

Submitter Information

EIN (Tax ID): _____-_____		Submitter (Facility) Name:	
Address:		Address 2:	City:
State:	Submitter Zip:	Provider Zip: *(If different)*	County Name:
Phone Number:		Email Address:	Fax Number:
Ordering Provider NPI:		Ordering Provider First and Last Name:	

Test Requested: ☒ COVID-19 Molecular Test (RT-PCR)

Specimen

Specimen source(s):
- ❑ NP Swab
- ❑ OP Swab
- ❑ Nasal Swab
- ❑ Mid-turbinate Swab

Transport Media:
- ❑ SLPH VTM
- ❑ Remel VTM
- ❑ MTM (i.e PrimeStore)
- ❑ Saline
- ❑ Commercial VTM/UTM
- ❑ Other: _____

Collector's Initials:

Collection Date(s): ____/____/____

Laboratory Number(s) *Do Not Write in this Space*

For more information, refer to website at http://slph.ncpublichealth.com