

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

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

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: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous	Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Isle <input type="checkbox"/> Asian <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Diagnosis Code(s) ICD-10 Reason for Encounter/Visit: <input type="checkbox"/> Encounter for Screening COVID-19 (U0001) <input type="checkbox"/> Other Code: _____ Prioritized Group: <input type="checkbox"/> Hospitalized Patient <input type="checkbox"/> Healthcare Professional or First Responder <input type="checkbox"/> Live in/Contact with High-Risk Setting/Congregate living facility <input type="checkbox"/> Higher Risk of Severe Illness <input type="checkbox"/> Uninsured <input type="checkbox"/> Post-mortem specimens			Alternate Group: <input type="checkbox"/> ILINet Surveillance* + Will be tested for both COVID-19 and Influenza. Answer the following for ILINet specimens: Flu vaccination in past year? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Recent travel history? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> <input type="checkbox"/> Other* _____ * Includes people who attended protests, rallies, mass gatherings, study participants, or other emerging groups		
Patient History	ICU Patient? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> First test? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Symptomatic? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>		Symptom onset date, if symptomatic? ____ / ____ / ____ Check any symptoms that apply: <input type="checkbox"/> Fever over 100.4F <input type="checkbox"/> Feeling feverish <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> New loss of taste <input type="checkbox"/> New loss of smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Runny nose <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea		
	The provider listed below certifies all information is correct and all questions answered to the best of their ability. _____ <div style="text-align: right;">Provider Initials</div>				
Submitter Information	EIN (Tax ID): _____ - _____		Submitter (Facility) Name:		
	Address:		Address 2:	City:	
	State:	Submitter Zip:	Provider Zip: <i>(if different)</i>	County Name:	
	Phone Number:		Email Address:	Fax Number:	
	Ordering Provider NPI:		Ordering Provider First and Last Name:		
Test Requested: <input checked="" type="checkbox"/> COVID-19 Molecular Test (RT-PCR) +/- Flu					
Specimen	Specimen source(s): <input type="checkbox"/> Nasal <input type="checkbox"/> Nasal mid-turbinate <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Oropharynx		Transport Media: <input type="checkbox"/> SLPH VTM <input type="checkbox"/> Remel VTM <input type="checkbox"/> MTM (i.e PrimeStore) <input type="checkbox"/> Saline <input type="checkbox"/> Commercial VTM/UTM <input type="checkbox"/> Other: _____	Collector's Initials:	Collection Date(s): ____ / ____ / ____
	Laboratory Number(s) <i>Do Not Write in this Space</i>				