District of Columbia ♦ Department of Forensic Sciences ♦ Public Health Laboratory
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COVID-19 Test Requisition Form

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CLIA#: 09D0968273

Patient Information

*Required Information

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐Male ☐Female ☐Other	Race/Ethnicity	
Address	City*	State*	ZIP
Sample ID (Laboratory ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (If not the Health Care Provider)	Last Name	First Name		
Telephone #* (primary)	Secure Fax #**	Email		
** Final report will be sent to the fax number above				

Specimen Information

Date of Collection* (MM/DD/YYYY):	Time of Collection*: ☐AM ☐PM

Reason for Submission*
☐Diagnostic ☐Outbreak ☐DC Health Request: DC Health Contact:_____

Specimen Type (check all that apply)*
☐Aptima Multitest Specimen Tube (Orange Label) ☐Aptima Specimen Transfer Tube (Green Label) ☐Swab ☐UTM ☐VTM
☐Sterile Container ☐Blood Tube (Plasma, Serum or Whole Blood)_____ ☐Other (specify)_____

Specimen Source*
☐Bronchoalveolar Lavage ☐Bronchial Wash ☐Nasal ☐Nasopharyngeal (NP) ☐Oropharyngeal (OP) ☐NP/OP
☐Sputum, expectorated ☐Sputum, induced ☐Throat ☐Other (specify)_____

Test Request (✓ requested tests)

☐ SARS CoV-2 Molecular Test (RT-PCR)

☐ SARS CoV-2 Serology Test (IgG only)

Clinical Symptoms

Has the patient experienced any symptoms? ☐Yes ☐No	Earliest Symptom Onset Date? _____
If the patient has experienced symptoms, please check all that apply:	
☐Fever	☐Cough
☐Shortness of breath/difficulty breathing	☐Muscle Pain
☐Chills	☐Headache
☐Repeated shaking with chills	☐Sore Throat
☐New Loss of Taste or Smell	☐Altered Mental Status/ Disoriented/ Confusion
☐Fatigue/Tiredness	☐Gastrointestinal (e.g nausea, vomiting, diarrhea)
☐Other_____	

Testing Priority

☐Routine Test Requested	☐STAT/Priority Test Requested

This section is for DC PHL use only

Specimen received by_____ Date/Time_____ Storage Temp_____

☐ Abbott ID Now COVID-19 ☐ Cepheid Xpert Xpress SARS-CoV-2 Test ☐ Panther Fusion SARS CoV-2 Assay ☐ Panther SARS CoV-2 Assay ☐ CDC 2019-nCoV Real-Time RT-PCR