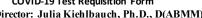


☐ Routine Test Requested

District of Columbia • Department of Forensic Sciences • Public Health Laboratory 401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464

COVID-19 Test Requisition Form





CLIA Director: Julia Kiehlbauch, Ph.D., D(ABMM) CLIA#: 09D0968273

Patient Information				*Required Information					
Last Name*		First Name*			Middle Initial	ddle Initial Suffix			
Date of Birth*			Sex*	Sex* Race/Ethnicity					
(MM/DD/YYYY)			☐ Mal	□ Male □ Female □ Other					
Address *			City*	ity* 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	:mail				
Specimen Information									
Date of Collection* (MM/DD/YYYY):				Time of Collection*:					
Collection Method: ☐ Provider Collection ☐ Self Collection (Provider Observed) ☐ Self Collection									
Reason for Submission* □ Diagnostic □ Dubreak □ 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 Storila Container D Blood Tube (Blooms Sorum or Whole Blood)									
☐ Sterile Container ☐ Blood Tube (Plasma, Serum or Whole Blood) ☐ Other (specify) ☐ Other (specify)									
Specimen Source* □ Bronchoalveolar Lavage □ Bronchial Wash □ Nasal- Mid Turbinate □ Nasal- Anterior Nares □ Nasopharyngeal (NP) □ Oropharyngeal (OP) □ NP/OP (Dual Swabs) □ Sputum, expectorated □ Sputum, induced □ Throat □ Other (specify) □ Other (specify) □ Sputum □ Sputum									
Test Request ✓ requested tests)									
□ SARS CoV-2 Molecular Test (RT-PCR) □			□ SAF	☐ SARS CoV-2 Serology Test (IgG only)					
Covid-19 Vaccine *									
☐ Yes ☐ Moderna ☐ 1 st Dose Only ☐ 1 st and 2 nd Dose Dates of Vaccination(s):									
□ No □ Pfizer □ 1 st Dose Only □ 1 st and 2 nd Dose Dates of Vaccination(s):									
Clinical Symptoms (Please check all that apply) *									
Has the patient experienced any symptoms? ☐ Yes ☐ No				Earliest Symptom Onset Date?					
☐ Fever	G .				☐ Sore Throat				
☐ Shortness of breath/difficulty breathing ☐ Cough					☐ Altered Mental Status/ Disoriented/ Confusion				
☐ Chills	☐ Muscle Pain	Muscle Pain		☐ Nausea/vomiting/diarrhea					
☐ New Loss of Taste or Smell	☐ Headache		□Other						
Test Priority									

☐ STAT/Priority Test Requested