OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

CORONAVIRUS DISEASE (COVID-19) MOLECULAR SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, MRN, etc.) *MAX. 17 CHARACTERS*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(last 4 only, optional)*	
COUNTY OF RESIDENCE	SEX (at birth) ❑ Female ❑ Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. *(optional)*		
RACE ❑ White ❑ Asian ❑ Black ❑ Other _____ ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander		
ETHNICITY ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Unknown		

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO. *(results will be sent to this number)*		

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❒ UNSAT | Reason:	ACC:
❒ SATISFACTORY	DE:
	CKD:

DATE OF COLLECTION:

SOURCE OF SPECIMEN:
❑ Nasopharyngeal *(other sources not acceptable)*

TEST(S) REQUESTED:
❑ SARS-CoV-2 qRT-PCR

SUBMITTED FOR:

❑ Surveillance	❑ First Responder
❑ Healthcare Worker	❑ Workplace
❑ Outbreak Investigation (**complete information below*)	

REQUIRED OUTBREAK INFORMATION*

OUTBREAK NUMBER _____

❑ Nursing Home / LTCF	❑ Daycare
❑ School	❑ Other

Is patient? ❑ Resident/Child ❑ Staff

REQUIRED PATIENT INFORMATION:

Illness Status ❑ Symptomatic ❑ Asymptomatic

Symptom Onset Date: _____ / _____ / _____

Patient Level of Care: ❑ Inpatient ❑ Outpatient

COMMENTS:

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Was sample frozen? ❑ Yes ❑ No

SAMPLE CONDITION:
❑ Ice Packs ❑ Frozen ❑ Room Temperature

VTM/UTM Volume: ❑ 3mL ❑ less than 3mL

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS