

**SARS-CoV-2 (virus that causes COVID-19) Testing Requisition**

Please make sure the information on the form is legible and complete.

SUBMITTER INFORMATION				PATIENT INFORMATION				
Patient ID Number 				PATIENT NAME (Last) 		First 	MI 	Suffix
Submitter (facility that will receive the final report) 				County of Residence 		Date of Birth 		
Street Address 				Address 				
City 		State 	Zip 	City 		State 	Zip Code 	
Phone Number 				Phone Number 				
Specimens Submitted (Please only submit one specimen type per patient) ☐ Nasopharyngeal swab (NP) ☐ Oropharyngeal swab (OP) ☐ Nasal mid-turbinate (NMT) ☐ Anterior nares (NS) swab ☐ Nasopharyngeal/Oropharyngeal combined swabs (NP/OP)				RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Pacific Islander/ Hawaiian ☐ White/ Caucasian ☐ Other				
Test Requested: ☐ SARS Coronavirus 2 Real-Time RT-PCR				ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Latino		SEX ☐ Male ☐ Female		
Date of Collection: 								

C. Required Epidemiological Information. Answer ALL of the below questions.

1. Is the patient symptomatic as defined by CDC? ☐ No ☐ Yes
2. If yes, what was the Date of Symptom Onset ____/____/____ (mm/dd/yyyy)
3. Is the patient hospitalized? ☐ No ☐ Yes ☐ Unknown

Instructions for Form 1198, SARS-CoV-2 (Virus that causes COVID-19) Testing Requisition

Purpose

To collect submitter information, patient demographics and specimen information for specimens submitted for SARS-CoV-2 (Virus that causes COVID-19) testing.

Instructions:

Submitter Information- Left hand side of requisition

Record all requested information

Patient ID Number: Enter the submitter's patient identification number.

Submitter Name: Enter the submitting facility's full name.

Street Address: Enter the submitting facility's street address

City: Enter the submitting facility's city

State: Enter the submitting facility's state

Zip: Enter the submitting facility's zip code

Phone Number: Enter the submitting facility's phone number

Contact Name: Enter the name of the submitting facility's contact if applicable

Contact: Enter the phone number of the submitting facility's contact if applicable

Patient Information – Right hand of requisition

Patient Name- Enter the patient's LAST NAME, FIRST NAME AND MIDDLE INITIAL in sequence. The spelling of the name on the laboratory slip and the specimen container/tube must be identical. **Name listed must be legal name; DO NOT use nicknames.**

County of Residence- Enter the county where the patient currently resides (Hinds, Rankin, etc).

Date of Birth- Provide in MM/DD/YY format.

Address - Enter the complete address where the patient currently resides.

City - Enter the name of the city in which the patient resides.

State - Enter the state in which the patient resides

Zip Code - Enter the Zip Code of the patient's address.

Phone Number – Enter patient's telephone number including area code.

Specimen Type: Submit a NP swab and an OP swab for each patient. If patient has a productive cough, submit one Lower Respiratory Specimen in addition to NP and OP swabs. Provide the Date of collection in MM/DD/YY format

Test Requested: Check the box by the appropriate test requested.

Race – Check the box associated with the patient's race

Ethnicity- Check the appropriate box

Gender- Check the appropriate box (male or female)

Required Epidemiological Information: Respond Yes or No to all questions. Provide all applicable information requested.

Office Mechanics and Filing – This form must accompany each patient for whom specimens are submitted to the MSDH Laboratory. A copy should be retained by the submitter as documentation of submission. Test results will be reported via computer generated report and forwarded to the submitter.

Retention Period – The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations.