



Surveillance

SARS-CoV-2 Enhanced Surveillance Submission 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
Submitting Facility Name			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)			RACE				
<input type="checkbox"/> Nasopharyngeal swab (NP) <input type="checkbox"/> Oropharyngeal swab (OP) <input type="checkbox"/> Nasal mid-turbinate (NMT) <input type="checkbox"/> Anterior nares (NS) swab			<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander/ Hawaiian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> Other				
Test Requested:			ETHNICITY		SEX		
<input type="checkbox"/> SARS-CoV-2 surveillance characterization			Hispanic or Latino		Male		
Date of Collection:			Non-Hispanic or Latino		Female		
Date of SARS CoV-2 positive test:							
Type of Test: Antigen PCR TMA							

C. Indication for SARS-CoV-2 Variant (VOC) Screening. Select the correct submission criteria list below:

Suspected re-infection identified by PCR testing.

Date of the original positive test? _____ Type of Test Antigen PCR TMA

Multitarget PCR assay with S gene dropout (S gene negative) and other gene target(s) positive with Ct<30.

Vaccinated individuals with subsequent laboratory-confirmed SARS-CoV-2 infection >2 weeks following receipt of the second dose in a 2-dose series, or >2 weeks following receipt of one dose of a single-dose vaccine. Date of last dose: _____ Vaccine Name: _____

Known or suspected outbreak event (minimum of 3 specimens and maximum of 5 specimens).

MSDH weekly surveillance request (up to 5 per week per facility).

Mississippi State Department of Health Form Instructions

SARS-CoV-2 (Virus that causes COVID-19) Surveillance Submission Requisition

FORM NUMBER F-1198-S

REVISION DATE March 12, 2021

RETENTION PERIOD The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations.

PURPOSE

To collect submitter information, patient demographics and specimen information for specimens submitted for SARS-CoV-2 Surveillance 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.