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

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

<table>
<thead>
<tr>
<th>SUBMITTER INFORMATION</th>
<th>PATIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID Number</td>
<td>PATIENT NAME (Last) First MI Suffix</td>
</tr>
<tr>
<td></td>
<td>County of Residence Date of Birth</td>
</tr>
<tr>
<td></td>
<td>Street Address Address</td>
</tr>
<tr>
<td></td>
<td>City State Zip City State Zip Code</td>
</tr>
<tr>
<td></td>
<td>Phone Number Phone Number</td>
</tr>
</tbody>
</table>

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

ETHNICITY

- [ ] Hispanic or Latino
- [ ] Non-Hispanic or Latino

SEX

- [ ] Male
- [ ] Female

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.