



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

Form with fields for Patient ID Number, Patient Name (Last, First, MI, Suffix), Clinic/Lab Name, County of Residence, Date of Birth, Street Address, Address, City, State, Zip, Phone Number, Contact Name of the clinician, RACE, ETHNICITY, Sex, and Contact Phone Number.

A. Test Requested:

[] SARS Coronavirus 2 Real-Time RT-PCR

B. Specimens Submitted

[] Nasopharyngeal swab (NP) in 2-3mL Viral Transport Media Date of Collection: _____

C. To determine patient's testing priority, please answer ALL of the below questions.

Is the patient:

1. Symptomatic with one or more of the following [] No [] Yes [] Fever with a temp of : _____ [] Cough [] Shortness of Breath

Date of Symptom Onset: _____ Did the patient die as a result of illness [] Yes [] No

2. Hospitalized? [] No [] Yes

If yes, Facility Name: _____

3. A resident of a long term care facility? [] No [] Yes

If yes, Facility Name: _____

4. A healthcare worker? [] No [] Yes

If yes, Facility Name: _____

5. Associated with a COVID-19 outbreak reported to the MSDH? [] No [] Yes

If yes, Outbreak Facility Name: _____

6. A healthcare acquired infection suspect? [] No [] Yes

If yes, Facility Name: _____

7. A contact to a known COVID-19 case? [] No [] Yes

D. Required Testing Information:

Was any additional Respiratory Virus Testing Performed: [] Yes [] No

If yes, check all that apply. Attach a report containing testing results

[] Influenza Test. List test name and results: _____

[] Respiratory Virus panel. List test name and results: _____

E. New Client Account Set-up for Fax Reporting.

Clinics/labs that are not current clients of the MPHL, must complete and submit MPHL form ISA0-13 to set-up fax reporting.

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 isolates 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.

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

Ethnicity- Check the appropriate box

Sex- Check the appropriate box (male or female)

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

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.

Patient Priority Information- Respond Yes or No to all questions. Provide all applicable information requested. Required testing information- Provide all requested testing results.

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.