COVID-19 Test Request Form

Please complete one form for each patient that COVID-19 testing is requested for. Include form with specimen submission.

REPORTER INFORMATION

Today's Date: _____ Hospital/Clinic: _____

Clinician Name: _____ Phone: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Phone: _____

Address: _____ City: _____

Zip Code: _____ County: _____ State: _____

Date of Birth: _____/_____/_____ Age: _____ **Years/Months** Sex: ☐ **Male** ☐ **Female**

Additional information **required** for testing:

Does the patient work in a healthcare facility or congregate setting? (e.g., long-term care facility, shelter, prison, jail)

☐ **YES** ☐ **NO** Facility Name:_____

Employee Occupation:_____

Did the patient work while ill? ☐ **YES** ☐ **NO**

Does the patient live in a congregate setting? (e.g., long-term care facility, shelter, group home, prison, jail)

☐ **YES** ☐ **NO** Facility Name:_____

Does the patient receive dialysis? ☐ **YES** ☐ **NO**

Does the patient work in a dialysis facility? ☐ **YES** ☐ **NO**

CLINICAL INFORMATION

Date of symptom onset: _____/_____/_____

Is patient hospitalized? ☐ Y ☐ N

Admit Date: _____/_____/_____

Hospital Name: _____

☐ Y ☐ N ICU Admission?

☐ Y ☐ N Intubated?

☐ Y ☐ N Deceased?

☐ Y ☐ N Chest X-ray or CT?

☐ Y ☐ N ECMO

Does the patient have underlying conditions?

☐ None ☐ Immunocompromised

☐ Unknown ☐ Pregnant

☐ Diabetes ☐ Chronic Lung Disease

☐ Hypertension ☐ Chronic Liver Disease

☐ Cardiac Disease ☐ Chronic Kidney Disease

☐ Other:_____

LABORATORY TESTING

☐ **YES** ☐ **NO** Has the patient been tested for influenza?

Result: ☐ **Positive** ☐ **Negative**

Test Type: ☐ **Rapid Test** ☐ **PCR**

☐ **YES** ☐ **NO** Has the patient been tested for any other viral respiratory illness?

Result: _____

COVID 2019 TESTING

Which specimen types have been sent to Minnesota Department of Health for COVID-19 testing?

☐ NP ☐ OP ☐ Other:_____ Specimen Collection Date:_____