*Lab Use Only*

Date received: _____/_____/_____
Rejection Criteria:
- ❑ Inappropriate temperature
- ❑ Sample >72 hours from collection
- ❑ Incomplete labelling
- ❑ Incorrect specimen type

# COVID-19

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

*Please Give All Information Requested* *Attach Printed Label Below*

**Patient Information**

| | | | | |
|---|---|---|---|---|
| Last Name | | | | |
| First Name | MI | | | |
| Address/Attention: | | | | |
| Street Address: | | | | |
| City: | State: | Zip: | County: | County Code: |
| Phone Number: | | Date of Birth: _____/____/_____ | | |
| Medical Record Number: | | Medicaid Number (if applicable): | | |

Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown

Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Isle ❑ Unknown

Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Prioritized Group:
- ❑ Hospitalized Patient
- ❑ First Responder/Healthcare Worker
- ❑ Live in/Contact with High-Risk Setting
- ❑ Higher Risk of Severe Illness

Alternate Group:
- ❑ ILInet Surveillance+
- ❑ Other_____

+For select providers. Will be tested for both COVID-19 and Influenza

**(ICD-10 Dx Code): U0001**

**Patient History**

The provider listed below certifies that the patient from whom this specimen was collected is from a prioritized group listed above and is exhibiting COVID-19 symptoms such as fever (subjective or objective) and/or symptoms of acute respiratory illness (e.g. cough, difficulty breathing).

_____
Provider Initials

Patient received influenza vaccination in the past year?
- ❑ No
- ❑ Yes

Patient has a recent travel history?
- ❑ No
- ❑ Yes, _____

**Submitter**

| | | |
|---|---|---|
| EIN (Tax ID): _____- _____ | Submitter (Facility) Name: | |
| Address: | Address 2: | City: |
| State: | Zip Code: | County Name: |
| Phone Number: | Email Address: | Fax Number: |
| Ordering Provider NPI: | Ordering Provider First and Last Name: | |

**Specimen**

| | | | |
|---|---|---|---|
| Specimen source(s): NP Swab | Collection Date(s): _____/_____/_____ | Collector's Initials: | Laboratory Number(s): *Do Not Write in this Space* |

**For Lab Use**

**Interpretation**:
- ❑ Negative: No virus detected
- ❑ Virus detected by molecular assay

**Results Telephoned:**
To:_____
Date/Time:_____
By: _____