NH PUBLIC HEALTH LABORATORIES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
29 Hazen Drive, Concord, NH 03301
Telephone: 603-271-4661, Fax: 603-271-2138

COVID-19 SARS-CoV2 TEST REQUISITION

http://www.dhhs.nh.gov/dphs/lab/documents/labrequisition.pdf

Place Barcode label here

Primary SUBMITTER INFORMATION - Please Print Legibly*

(Fill out this section as the facility or healthcare provider submitting the specimen)

Submitter Facility Code: _____

Submitter Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone No.: _____ Fax No.: _____

Physician (Full Name): _____

***Note:** The laboratory cannot give results out to another healthcare provider without consent from the primary submitter. See next column to add secondary submitter information.*

HAS THIS SAMPLE BEEN REQUESTED BY THE NH STATE PUBLIC HEALTH DEPT? ___Y ___N

PATIENT INFORMATION - Please Print Legibly

***NOTE:* All specimens MUST be labeled with Patient Name or ID #, Date of Birth and Date of Collection**

Last Name: _____

First Name: _____

Patient ID #: _____

D.O.B:_____ **Age:** _____ **Sex:** M F
M M / D D / Y Y

Address: _____

City: _____ **State:** _____ **Zip:** _____

County: _____ **Patient Tel #:** _____

RACE (Circle One): WHITE BLACK ASIAN NATIVE - American/Alaskan MULTIRACIAL HAWAIIAN/PACIFIC ISLANDER UNKNOWN OTHER _____

ETHNICITY (Circle One): NON-HISPANIC HISPANIC UNKNOWN

SPECIMEN INFORMATION: (Must fill out or testing will be delayed)

DATE of collection: _____

TIME of collection: _____

MATRIX:
____ VTM
____ SALINE
____ OTHER: _____

Swab type:
____ Anterior Nares (Nasal)
____ Mid-Turbinate
____ Nasopharyngeal
____ Oropharyngeal

Other type:
____ Sputum
____ Tissue (Specify) _____
____ Fluid (Specify) _____
____ Other (Specify) _____

Secondary SUBMITTER INFORMATION - Please Print Legibly

(Fill out this section if results need to be reported to another facility or healthcare provider)

Secondary Submitter Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone No.: _____ Fax No.: _____

Physician (Full Name): _____

CHECK APPROPRIATE TEST REQUEST:

☐ **SARS-CoV2 PCR** (if positive, may reflex to variant testing)

☐ **VARIANT SEQUENCING ONLY****

Test Method: _____ CT Value: _____

**For epidemiological purposes only. No reports will be issued to submitter.

Additional patient information requested:

Check if patient is/has:
____ Correctional Facility Staff or Inmate
____ Emergency Responder
____ Healthcare Worker
____ Homeless
____ Inpatient - (Circle one: ER ICU Regular bed Unknown)
____ Long Term Care Facility Resident (LTCF)
____ LTCF Resident Testing/Surveillance Program
____ LTCF Staff Testing
____ Outbreak – Facility: _____
____ Pregnant
____ Previously diagnosed with COVID-19 in the past 90 days - concern for re-infection
____ Resident - (Circle one: Group Home Setting or Foster care)
____ Resident - Other not listed above: _____
____ Travel - Domestic in the past 14 days
Location & dates of travel: _____
____ Travel - International in the past 14 days
Location & dates of travel: _____
____ Vaccinated fully against COVID-19 - concern for new infection
____ Vaccine Breakthrough

Patient Symptoms:
____ Patient is Symptomatic
____ Patient is Asymptomatic[I] (if selected, answer questions below)

[I]If patient is asymptomatic:
a. Did patient have direct exposure to a confirmed case of COVID-19?
____Yes ____ No

b. Date of exposure: _____(can be approximate date)

COMMENTS:

PHL USE ONLY

Other Test Requested or Additional Comments and Remarks: _____ 8/13/2021