Health and Environment Testing Laboratory SARS-CoV-2 Specimen Submission Form

*This form **must be submitted** with SARS-CoV-2 test requests. Specimens that are submitted for SARS-CoV-2 testing without this form or with incomplete information may be delayed or not tested.* rev. 1/7/2022

Facility Information

Facility:

Contact Person:

Address:

Telephone:

Secure Fax#:

☐ Ordering Provider Name:

Telephone:

OR

☐ Test conducted under medical authorization for the State of Maine COVID-19 Testing Standing Order

Patient Information

Patient Name (Last, First, MI)

DOB: ____ /____ /____ (mm/dd/yyyy)

Patient Gender: ☐ Male ☐Female ☐Other

Patient Address

Patient Phone Number:

Patient preferred language, if not English:
Please specify
☐ _____

Ethnicity: ☐ Hispanic or Latinx
☐ Non-Hispanic

Race: ☐ White
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Other
☐ Two or more races

Special Conditions: Please indicate if any of the following conditions exist:

Hospitalized	☐yes	☐no	Facility name_____
Health Care Worker:	☐yes	☐no	Facility name_____
First Responder (Police, Fire, EMS):	☐yes	☐no	Organization_____
Congregate Setting (LTC, Jail, shelter, farm, etc)	☐yes	☐no	Facility name_____
Patients older than 60 years	☐yes	☐no	
Pregnant	☐yes	☐no	

Specimen Collection Information

Please check only one source – Supervised OR Clinician collected

☐ Supervised onsite self-collection (Nasal mid-turbinate)
☐ Supervised onsite self-collection (Anterior Nares)

FOR ANY SPECIMEN TYPE:
Date of Specimen Collection ____ /____ /____ (mm/dd/yyyy)

CLINICIAN COLLECTED – Check source below
☐ Nasopharyngeal
☐ Oropharyngeal (Throat)
☐ Anterior Nares (nasal swab)
☐ Nasal mid-turbinate (nasal swab)
☐ Other (_____) please specify

Clinical Information

☐ **Symptomatic (please indicate sx, below)** **OR** ☐ **Asymptomatic**

☐ Fever or chills ☐ Cough
☐ Fatigue ☐ Muscle or body aches
☐ Headache ☐ Sore throat
☐ Nausea or vomiting ☐ Diarrhea

☐ Shortness of breath or difficulty breathing
☐ New loss of taste or smell
☐ Congestion or runny nose

Date of symptom onset: ____ /____ /____ (mm/dd/yyyy)

1st Vaccination ____ /____ /____ (mm/dd/yyyy) **mfg** _____

2nd Vaccination ____ /____ /____ (mm/dd/yyyy)

Patient with underlying medical conditions? ☐Yes (please specify) _____ ☐No