DEPARTMENT OF HEALTH

Submit Sample(s) to:
MN Public Health Laboratory
Infectious Disease Lab
601 Robert St. N
St. Paul, MN 55155

Phone (651) 201-5200
Fax (651) 201-4538
Specimen Receiving (651) 201-4953
CLIA# 24D0651409

MDH Lab Use Only
Condition:
Ambient
Refrigerated
Frozen
Barcode Label

* Required Fields

COVID-19 Specimen Submission and Test Request Form

Submitter

*Submitting Facility: (Results sent here)

*Address:

City: State: Zip:

Name of Person Filling Out Form:

Phone # for questions/alert values:

Ordering Provider:

Project Number: 2618

Patient

*Last Name:

*First Name: MI:

Patient Phone Number:

Address:

City: State: Zip:

County:

Patient MRN #:

*DOB (mm/dd/yyyy):

Sex:
- ☐ Male
- ☐ Female
- ☐ Other or Unknown

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other not listed
- ☐ Unknown/Not Provided

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Not Provided

Specimen

Sample ID:

*Date of Collection (mm/dd/yyyy):

Time of Collection (##:##): AM ☐ PM ☐

* Transport Media:
- ☐ VTM/UTM
- ☐ Saline

* Storage Condition Prior to Transport:
- ☐ Refrigerated
- ☐ Frozen

*Source:
- ☐ Nasal Swab
- ☐ Nasopharyngeal Swab (NP Swab)
- ☐ Oropharyngeal Swab (OP Swab, Throat Swab)

Other, specify:

Test and Epidemiology Information

Collection Facility Information

*Collection Facility Name:

☐ Collection Facility is the same as Submitting Facility. Skip to section - Facility Type

Address:

City: State: Zip:

*Facility Type:
- ☐ Nursing Home
- ☐ Retirement Home
- ☐ Long Term Care Hospital
- ☐ Behavioral Health or Treatment
- ☐ Hospital or Clinic
- ☐ Correctional Facility
- ☐ Military Accommodation
- ☐ Sheltered Housing
- ☐ Other, specify:

Patient Contact/Tracing Information

*Is the patient a resident of the above facility?
☐ Yes ☐ No ☐ Unknown

*Is the patient a healthcare worker with direct patient contact?
☐ Yes ☐ No ☐ Unknown

*Does patient have symptoms? If yes, check all that apply:
- ☐ sore throat
- ☐ nasal congestion
- ☐ runny nose
- ☐ cough
- ☐ new loss of taste
- ☐ new loss of smell
- ☐ headache
- ☐ fever over 100.4
- ☐ feeling feverish
- ☐ shortness of breath
- ☐ difficulty breathing
- ☐ chills
- ☐ fatigue
- ☐ muscle or body aches
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea

Onset Date:

*Hospitalization:
☐ Patient is Not Hospitalized ☐ Patient is Hospitalized ☐ Patient is in ICU

*If patient is female, are they currently pregnant?
☐ No ☐ Yes ☐ Unknown

Patient Email Address:

Preferred Language:

School (K-12, college /university) or Childcare Attendance:

Employer:

Occupation:

Test Information and Comments

Test Requested: ☑ Influenza and COVID-19 PCR (various assays)

Submitting Laboratory - Specify Any Other Information or Comments: