District of Columbia ♦ Department of Forensic Sciences ♦ Public Health Laboratory
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COVID-19 Test Requisition Form

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CLIA#: 09D0968273

Patient Information

*Required Information

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	Race/Ethnicity	
Address *	City*	State*	ZIP
Sample ID (Laboratory ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (If not the Health Care Provider)	Last Name	First Name		
Telephone #* (primary)	Secure Fax #**	Email		

Specimen Information

Date of Collection* (MM/DD/YYYY): Time of Collection*: ☐ AM ☐ PM

Collection Method: ☐ Provider Collection ☐ Self Collection (Provider Observed) ☐ Self Collection

Reason for Submission*
☐ Diagnostic ☐ Outbreak ☐ DC Health Request: DC Health Contact:_____

Specimen Type (check all that apply)*
☐ Aptima Multitest Specimen Tube (Orange Label) ☐ Aptima Specimen Transfer Tube (Green Label) ☐ Swab ☐ UTM ☐ VTM
☐ Sterile Container ☐ Blood Tube (Plasma, Serum or Whole Blood)_____ ☐ Other (specify)_____

Specimen Source*
☐ Bronchoalveolar Lavage ☐ Bronchial Wash ☐ Nasal- Mid Turbinate ☐ Nasal- Anterior Nares ☐ Nasopharyngeal (NP)
☐ Oropharyngeal (OP) ☐ NP/OP (Dual Swabs) ☐ Sputum, expectorated ☐ Sputum, induced ☐ Throat
☐ Other (specify)_____

Test Request (✓ requested tests)

☐ SARS CoV-2 Molecular Test (RT-PCR)	☐ SARS CoV-2 Serology Test (IgG only)

Covid-19 Vaccine *

☐ Yes	☐ Moderna	☐ 1st Dose Only	☐ 1st and 2nd Dose	Dates of Vaccination(s): _____
☐ No	☐ Pfizer	☐ 1st Dose Only	☐ 1st and 2nd Dose	Dates of Vaccination(s): _____

Clinical Symptoms (Please check all that apply) *

Has the patient experienced any symptoms? ☐ Yes ☐ No Earliest Symptom Onset Date? _____

☐ Fever	☐ Fatigue/Tiredness	☐ Sore Throat
☐ Shortness of breath/difficulty breathing	☐ Cough	☐ Altered Mental Status/ Disoriented/ Confusion
☐ Chills	☐ Muscle Pain	☐ Nausea/vomiting/diarrhea
☐ New Loss of Taste or Smell	☐ Headache	☐ Other_____

Test Priority

☐ Routine Test Requested	☐ STAT/Priority Test Requested