

Commonwealth of Virginia
 Department of General Services
 Division of Consolidated Laboratory Services
 Richmond, Virginia

DCLS COVID-19 Submission Form

PATIENT INFORMATION				SUBMITTER INFORMATION			
Last Name:				Submitting Facility:			
First Name:				Address:			
Birth Date: / /		Phone:		City:		State:	Zip code:
Address:				Phone:		Fax:	
City:		State:	Zip code:	Attending Clinician:			
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Race:		Attending Clinician Phone:			
MRN:		Patient ID:		Public Health Dept Contact:			
Client External ID (VDH/DCLS#):				Public Health Contact Phone:			
PATIENT MEDICAL HISTORY							
Disease Suspected or Diagnosis: COVID-19							
Date of Onset: / /				Deceased Date: / /			
Signs/Symptoms: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Body Aches <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Taste/Smell <input type="checkbox"/> Myalgia/Arthralgia <input type="checkbox"/> Nausea <input type="checkbox"/> Pneumonia <input type="checkbox"/> Productive Cough <input type="checkbox"/> Rash <input type="checkbox"/> Respiratory <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:							
Recent Exposure (if applicable): <input type="checkbox"/> Contact w/ COVID-19 Positive Person <input type="checkbox"/> Other (Explain):							
OUTBREAK INFORMATION							
VDH Designated Outbreak #:							
Role of Patient: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Staff <input type="checkbox"/> Patient <input type="checkbox"/> Resident <input type="checkbox"/> Food Handler <input type="checkbox"/> Other:							
SPECIMEN COLLECTION INFORMATION							
Date Collected: / /				Time of Collection: : (military time)			
Reason for Test Request: <input type="checkbox"/> Isolate for ID/Confirmation <input type="checkbox"/> VDH Reportable Disease Compliance <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnosis <input type="checkbox"/> PPS <input type="checkbox"/> Contact/Suspected Carrier <input type="checkbox"/> Clearance/Release <input type="checkbox"/> Other:							
Specimen Source: <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Oropharyngeal/Throat Swab <input type="checkbox"/> Nose (Nasal Passage) <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> BAL <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other:							
ADDITIONAL INFORMATION				DCLS STATE LAB USE ONLY:			
				Place DCLS Label in space provided.			