

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:		M.I.	Address:		
Birth Date: / /	<input type="checkbox"/> Male <input type="checkbox"/> Female		City:		
Address:			State:	Submitter Zip code:	
City:	State:	Zip code:	Phone:		
County:			Fax:		
MRN:	Patient ID:		Attending Clinician:		Clinician Zip code:
Client External ID (VDH/DCLS#):			Attending Clinician Phone:		
Race:	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		Public Health Dept Contact:		
Phone:	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> UNK <input type="checkbox"/> No		Public Health Contact Phone:		
PATIENT MEDICAL HISTORY					
Disease Suspected or Diagnosis: <b>COVID-19</b>					
Reason for Test Request: <input type="checkbox"/> COVID-19 Contact/Suspected Carrier <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnosis <input type="checkbox"/> Clearance/Release <input type="checkbox"/> VDH Reportable Disease Compliance <input type="checkbox"/> Other:					
Patient's First COVID Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK		Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK		In ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK	
Employed in Health? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK		* Resident in a congregate care setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK			
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK		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"/> Malaise/Fatigue <input type="checkbox"/> Myalgia <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nausea <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rash <input type="checkbox"/> Runny Nose <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Sore Throat <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:					
OUTBREAK INFORMATION					
VDH Designated Outbreak #:			Site/Event Location:		
Patient Role: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Healthcare Worker <input type="checkbox"/> Staff <input type="checkbox"/> Patient <input type="checkbox"/> Resident <input type="checkbox"/> Other:					
SPECIMEN COLLECTION INFORMATION					
Date Collected: / /			Time of Collection: : (military time)		
Specimen Source: <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Oropharyngeal/Throat Swab <input type="checkbox"/> Nose (Nasal Passage) <input type="checkbox"/> Saliva <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> BAL <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Tracheal Aspirate <input type="checkbox"/> Other:					
ADDITIONAL INFORMATION			DCLS STATE LAB USE ONLY:		
			Place DCLS Label in space provided.		

\* The term **Congregate Care Setting** represents any nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting.