


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

DCLS COVID-19 Submission Form

***HIGHLIGHTED FIELDS ARE THE MINIMUM REQUIREMENTS - Patient Name on sample must match form exactly.**

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:	
Client External ID (VDH/DCLS#):				Clinician Zip code:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		Attending Clinician Phone:	
Phone:		Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> UNK <input type="checkbox"/> No		Public Health Dept Contact:	
Public Health Contact Phone:					
PATIENT MEDICAL HISTORY					
Disease Suspected or Diagnosis: COVID-19					
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"/> Reinfection <input type="checkbox"/> PPS <input type="checkbox"/> Community Testing Event (CTE) <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			
Received COVID Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Last Vaccine: / /		Vaccine Maker:	Total # Doses Received:
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				<div style="text-align: center;">  Scan for Video Tutorial </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> DCLS STATE LAB USE ONLY: Place DCLS Label in this space. </div>	

****Congregate Care Setting** represents any nursing homes, correctional or treatment facilities, group homes, homeless shelters, or similar setting.