

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: / /		<input type="checkbox"/> Male <input type="checkbox"/> Female		City:		State: Zip code:
Address:				Phone:		
City:		State:	Zip code:	Fax:		
MRN:		Patient ID:		Attending Clinician:		
Client External ID (VDH/DCLS#):				Attending Clinician Phone:		
Race:				Public Health Dept Contact:		
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		Phone:		Public Health Contact Phone:		
PATIENT MEDICAL HISTORY						
Disease Suspected or Diagnosis: <b>COVID-19</b>						
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. <div style="border: 1px solid black; width: 100%; height: 80px; margin-top: 5px;"></div>		