NH PUBLIC HEALTH LABORATORIES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
29 Hazen Drive, Concord, NH 03301
Telephone: 603-271-4661, Fax: 603-271-2138

COVID-19 TEST REQUISITION

http://www.dhhs.nh.gov/dphs/lab/documents/labrequisition.pdf

Place Barcode label here

Primary SUBMITTER INFORMATION - Please Print Legibly*

(Fill out this section as the facility or healthcare provider submitting the specimen)

Submitter Facility Code: _____

Submitter Facility Name: __**NH DEPARTMENT OF SAFETY**____

Address: __**33 HAZEN DR** _____ City: __**CONCORD**___

State: **NH**_ Zip: __**03305**_ Telephone No.: __**(603) 568-0969**__

Fax No.: **(603) 223-4294** joey.scollan@dos.nh.gov

Physician (Full Name): **JOEY SCOLLAN, DO, DOS MED. DIR.**

***Note:** The laboratory cannot give results out to another healthcare provider without consent from the primary submitter. See next column to add secondary submitter information.*

PATIENT INFORMATION - Please Print Legibly

***NOTE:* All specimens MUST be labeled with Date of Birth and Date of Collection**

Last Name: _____

First Name: _____

Patient ID #: _____

D.O.B:_____ **Age:** _____ **Sex:** M F
M M / D D / Y Y

Address: _____

City: _____ **State:** _____ **Zip:** _____

County: _____ **Patient Tel #:** _____

RACE (Circle One): WHITE BLACK ASIAN NATIVE - American/Alaskan
MULTIRACIAL HAWAIIAN/PACIFIC ISLANDER UNKNOWN OTHER _____

ETHNICITY (Circle One): NON-HISPANIC HISPANIC UNKNOWN

SPECIMEN INFORMATION: (Must fill out or testing will be delayed)

DATE of collection: _____

TIME of collection: _____

MATRIX:
____ VTM
____ SALINE
____ OTHER: _____

SITE/SOURCE of Specimen (please check):

Swab type:
____ Anterior Nares (Nasal)
____ Mid-Turbinate
____ Nasopharyngeal
____ Oropharyngeal

Other type:
____ Sputum
____ Tissue (Specify) _____
____ Fluid (Specify) _____
____ Other (Specify) _____

Secondary SUBMITTER INFORMATION - Please Print Legibly

(Fill out this section if results need to be reported to another facility or healthcare provider)

Submitter Facility Code: _____

Submitter Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone No.: _____ Fax No.: _____

Physician (Full Name): _____

If testing occurred at a State sponsored site, indicate location:

_____

_____

Additional patient information requested:

Check if patient is:

____ Healthcare Worker
____ Inpatient - (Circle one: ER ICU Regular bed Unknown)
__XX__ Emergency Responder
____ Long Term Care Facility Resident (LTCF)
____ LTCF Resident Testing/Surveillance Program
____ LTCF Staff Testing
____ Work at a Facility or Business with an Outbreak
____ Correctional Facility Staff or Inmate
____ Pregnant
____ Homeless
____ Resident - (Circle one: Group Home Setting or Foster care)
____ Resident - Other not listed above: _____

Patient Symptoms:

____ Patient is Symptomatic

____ Patient is Asymptomatic‡ (if selected, answer questions below)

‡If patient is asymptomatic:

a. Did patient have direct exposure to a confirmed case of COVID-19? ____Yes ____ No
b. Date of exposure: _____ (can be approximate date) (If no to question above, skip to c.)
c. Did patient request testing without any known risk factors? ____Yes ____ No
d. Does patient have any other reason to request testing?

_____

COMMENTS:

PHL USE ONLY:

Other Test Requested or Additional Comments and Remarks: _____6/14/2020