COVID-19 TEST REQUEST FORM

UTAH PUBLIC HEALTH LABORATORY	FOR UPHL USE ONLY	LAB#
4431 SOUTH 2700 WEST TAYLORSVILLE, UTAH 84129 TELEPHONE: (801) 965-2400 FAX: (801) 536-0473 http://health.utah.gov/lab/infectious-diseases		DATE STAMP

PLEASE PRINT CLEARLY AND FILL OUT AS COMPLETELY AS POSSIBLE.

PATIENT INFORMATION:

PATIENT STATE OF RESIDENCE	PATIENT COUNTY OF RESIDENCE	ZIP CODE	DATE OF BIRTH (mm/dd/yyyy)	AGE	SEX
			_____/_____/_____		M F

LAST NAME	FIRST NAME	PATIENT ID #	PATIENT`S PHONE

FACILITY ID #	ETHNICITY	RACE
	[ ] Hispanic [ ] Non-Hispanic	[ ] White [ ] Black or African American [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian or other Pacific Islander

PROVIDER INFORMATION		SPECIMEN COLLECTION DATE AND TIME
Provider Code:	Physician: _____ Provider Phone: _____ Provider Email: _____ Secure Fax #: _____	(mm/dd/yy) _____/_____/_____ Time: _____

SPECIMEN SOURCE/SITE:

[ ] Blood
[ ] Plasma
[ ] Serum
[ ] Sputum
[ ] Saliva

[ ] Nasopharyngeal swab
[ ] Nasal swab
[ ] Oropharyngeal swab
[ ] (Endo)tracheal aspirate/wash
[ ] Bronchoalveolar lavage

[ ] Viral RNA (for sequencing)

TEST SELECTION:

SEROLOGY:
[ ] SARS-CoV-2 anti-S IgG ELISA

NAAT:
[ ] SARS-CoV-2 detection by PCR or TMA

NEXT GENERATION SEQUENCING:
[ ] SARS-CoV-2 genome sequencing

ADDITIONAL INFORMATION

[ ] Other Disease Suspected: _____

[ ] Referral Test (additional form(s) **REQUIRED**)
***Contact UPHL for additional form(s)**

COMMENTS: