OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

CORONAVIRUS DISEASE (COVID-19) SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *MAX. 17 CHARACTERS*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(last 4 only, optional)*	
COUNTY OF RESIDENCE	SEX (at birth) ❑ Female ❑ Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. *(optional)*		
nCoV ID (REQUIRED)		

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO.		

DATE OF COLLECTION:

SITE/SOURCE OF SPECIMEN:	
❑ Nasopharyngeal	❑ Sputum
❑ Oropharyngeal (throat)	❑ NP/OP

TEST(S) REQUESTED:
MOLECULAR
❑ Respiratory Pathogen Panel
❑ nCoV-19 qRT-PCR

Optional Respiratory Specimen Data

Symptom Onset Date: / /

Patient Level of Care: ❑ Inpatient ❑ Outpatient

Was specimen pre-screened using a molecular assay for respiratory pathogens? ❑ Yes ❑ No

What assay was used?:

❑ GenMark ePlex ❑ Luminex VERIGENE®
❑ BioFire FilmArray® ❑ LDT
❑ Hologic Panther Fusion® ❑ Other _____

Result:

COMMENTS:

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❑ UNSAT | Reason: ❑ UNRELIABLE | Reason: ❑ SATISFACTORY	ACC: DE: CKD:

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS