



Tennessee Department of Health  
Division of Laboratory Services  
COVID-19 Submission Requisition

**Place State Lab Accession  
Label Here**  
(TDH use only)

**\*Indicates Required Fields**

Final test reports cannot be issued if required information is missing

**SPECIMEN COLLECTION INFORMATION**

<b>*Last Name:</b>		<b>*First Name:</b>		MI:
<b>*DOB:</b>	<b>*Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous <input type="checkbox"/> Other <input type="checkbox"/> Unk		<b>*Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Refused to answer	
<b>*Race:</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (_____) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused to answer				
<b>*Address:</b>			<b>*County of Residence:</b>	
<b>*City:</b>	<b>*State:</b>	<b>*Zip Code:</b>	<b>*Date of Collection:</b>	
<b>*Specimen Type</b> (please check one): <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Nasal <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Sputum <input type="checkbox"/> Nasal aspirate <input type="checkbox"/> Nasal wash <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Other (please specify) _____				
<b>*Patient Phone Number:</b> ( )		Outbreak/Event ID:		PUI ID:

**Unlabeled or mislabeled specimens cannot be tested; two distinct identifiers required on each tube.**

**SUBMITTER INFORMATION**

<b>*Submitting Facility:</b>	Patient Medical Record Number:		
<b>*Address:</b>	Phone Number: ( )	Fax Number: ( )	
<b>*City:</b>	<b>*State:</b>	<b>*Zip Code:</b>	
<b>*Ordering Provider:</b>	<b>*Phone Number:</b> ( )	Fax Number: ( )	

**FINAL REPORT DELIVERY**

<b>*Final Report Delivery Same as Submitting Facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>*If no, Final Report Delivery Entity:</b>	Email:	
<b>*Address:</b>	Phone Number: ( )	Fax Number: ( )
<b>*City:</b>	<b>*State:</b>	<b>*Zip Code:</b>
Point of Contact:	Phone Number: ( )	Fax Number: ( )

**\*TEST REQUESTED**

- COVID-19 RNA PCR
- COVID-19 IgG EIA

**ADDITIONAL PATIENT INFORMATION**

<b>*First COVID-19 test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>*Hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>*Employed in healthcare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>*Intensive Care Unit (ICU)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>*Symptomatic as defined by CDC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Date of Symptom Onset: _____ (MM/DD/YYYY)	<b>*Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A

**Resident in a congregate care setting<sup>1</sup>?**  Yes  No  Unknown

<sup>1</sup>Including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting

**LABORATORY FACILITIES**

<b>Nashville Laboratory:</b> P.O.Box 305130, Nashville, TN 37230 (USPS) <b>OR</b> 630 Hart Lane, Nashville, TN 37216 (FedEx, UPS, courier delivery) Main Line: (615) 262-6300 Richard Steece, PhD, D(ABMM), Public Health Laboratory Director	<b>Knoxville Regional Laboratory:</b> 2101 Medical Center Way, Knoxville, TN 37920 Main Line: (865) 549-5201 George J. Dizikes, PhD, HCLD/CC (ABB), Public Health Laboratory Director
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