Tennessee Department of Health
Division of Laboratory Services
SARS-CoV-2
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

***Last Name:**	***First Name:**	MI:
***DOB:**	***Sex:** □ Male □ Female □ Other □ Unknown	***Ethnicity:** □ Hispanic □ Non-Hispanic
***Race:** □ American Indian □ Asian □ Black □ Hawaiian/Pacific Islander □ White □ Other (_____)		
***Address:**		***County of Residence:**
***City:**	***State:** / ***Zip Code:**	***Date of Collection:**

***Specimen Type** (please check one): PCR and Sequencing: ☐Nasopharyngeal ☐ Nasal
Serology: ☐Serum ☐Plasma

***Patient Phone Number:**	Outbreak/Event ID:	PUI ID:

Unlabeled or mislabeled specimens cannot be tested; two distinct identifiers are required on each tube that match information on the requisition.

SUBMITTER INFORMATION

***Submitting Facility:**	Patient Medical Record Number:	
***Address:**	Phone Number:	Fax Number:
***City:**	***State:**	***Zip Code:**
***Ordering Provider:**	***Phone Number:**	Fax Number:

FINAL REPORT DELIVERY

***Final Report Delivery Same as Submitting Facility?** □ Yes □ No

***If no, Final Report Delivery Entity:**	Email:	
***Address:**	Phone Number:	Fax Number:
***City:**	***State:**	***Zip Code:**
Point of Contact:	Phone Number:	Fax Number:

*TEST REQUESTED

☐ **SARS-CoV-2 PCR** ☐ **SARS-CoV-2 Serology**

ADDITIONAL PATIENT INFORMATION

***First COVID-19 test?** □ Yes □ No □ Unknown | ***Date of most recent positive SARS-CoV2 test?** _____

***Has the patient had two (2) positive SARS-CoV-2 test results (PCR or antigen) > 90 days apart?** □ Yes □ No □ Unknown

***Symptomatic as defined by CDC?** □ Yes □ No □ Unknown | If yes, Date of Symptom Onset: _____

***Hospitalized?** □ Yes □ No □ Unknown | ***Intensive Care Unit (ICU)?** □ Yes □ No □ Unknown

***Deceased?** □ Yes □ No □ Unknown | If yes, Date of Death: _____

***Employed in healthcare?** □ Yes □ No □ Unknown | ***Pregnant?** □ N/A □ Yes □ No □ Unknown

Resident in a congregate care setting[1]? □ Yes □ No □ Unknown

[1]Including nursing homes, assisted living facilities, residential facilities for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelters, foster care facilities, correctional facilities, or other settings.

Is the patient part of an identified cluster of five (5) or more cases? □ Yes □ No □ Unknown

***Is the patient fully/partially vaccinated?** □ Yes □ No □ Unknown

***Date Vaccine Dose #1 (if applicable):** _____ ***Vaccine Manufacturer:** □ Pfizer □ Moderna □ J&J □ Other _____

***Date Vaccine Dose #2 (if applicable):** _____ ***Vaccine Manufacturer:** □ Pfizer □ Moderna □ J&J □ Other _____

***Date Vaccine Dose #3 (if applicable):** _____ ***Vaccine Manufacturer:** □ Pfizer □ Moderna □ J&J □ Other _____

LABORATORY FACILITIES

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630 Hart Lane, Nashville, TN 37216 (FedEx, UPS, courier delivery)
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Kara Levinson, PhD, MPH, D(ABMM), Director

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Kara Levinson, PhD, MPH, D(ABMM), Interim Director