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Test Requisition Form

Patient Information

Last Name:_____ First Name:_____
Date of Birth:_____ Sex: ☐ Female ☐ Male ☐ Unknown/Other
Role: ☐ Student ☐ School staff ☐ Community member (must live with student or school staff & have symptoms)

Sample information

Date collected:_____	Time collected:_____	Collected by:_____
TEST ORDER:	☐ COVID-19 Rapid Antigen (AG) test* POC Test code (SCOV2-AG) Specimen type: Nasal Swab	☐ COVID-19 Viral PCR test rRT-PCR Test code (SCOV2PCR+) Specimen type: Nasal Swab

- Note: if Rapid Antigen (Ag) test is POSITIVE, a follow-up PCR test will be conducted to confirm the result.

SYMPTOMS:		Temperature Check: _____	
☐ Loss of taste or smell	☐ Cough, sore throat, congestion, or shortness of breath	☐ Flu-like symptoms (chills, runny / stuffy nose, body aches, headache)	☐ Nausea, vomiting or diarrhea

If the patient is not pre-registered, complete the information below:

Patient Address

Address:_____ City:_____ State: _____ ZIP: _____
County:_____ Phone: _____ e-mail:_____
Race: _____ Ethnicity: _____

Patient/Guardian Informed Consent

I consent to the collection of specimens for the purpose of SARS-CoV-2 testing, and certify that the tests ordered have been explained to me by an authorized health care provider. I understand that my results will be distributed to me by my provider or securely emailed to me and reported to the appropriate state agencies. All personal and medical information will be kept confidential in accord with applicable laws and regulations. If patient is under 18, parent or guardian signature is required, unless pre-registration and consent is completed.

Signature: _____ Date: _____
(if under 18 years old, parent/guardian must sign)

Test Result

TESTING RESULTS:			
COVID-19 Test Result	☐ POSITIVE*	☐ NEGATIVE	☐ INVALID
COVID-19 Confirmation (optional test for confirmation)	☐ POSITIVE*	☐ NEGATIVE	☐ INVALID

Copy for Student to Bring to Class *(if applicable)*

Name: _____ *Date:* _____

COVID-19 Test Result	☐ POSITIVE*	☐ NEGATIVE	☐ INVALID