DALLAS COUNTY HEALTH AND HUMAN SERVICES

DCHHS Laboratory Test Request Form — Novel Coronavirus PCR

- See DCHHS Submission Instructions for COVID-19 Virus Testing at: www.dallascounty.org/departments/dchhs/2019-novel-coronavirus.php.
- DCHHS LRN lab can ONLY accept specimens from residents of counties comprising its service area: ***Collin, Dallas, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, Rains, Rockwall, and Van Zandt***
- For all non-Dallas County residents, submitter must obtain prior approval of the respective County/State health department, and approval must accompany this form
- Test results will be transmitted by fax to the listed submitter, or for non-Dallas residents to the respective County or State regional health department

= REQUIRED Fields—Omission of required information may result in inability to test. Completed form MUST accompany submitted specimens.

PATIENT

*Last name:		*First name:		ID/MRN:	
*DOB:	Age:	*Sex: ☐ M ☐ F	*Race:	*Eth: ☐ Hispanic ☐ Non-Hispanic	Patient Phone:
*Address:		*City:	*State:	*County:	Zip Code:

REQ.

*Submitting Facility Name:	*Contact Name:	
Contact Email:	*Phone:	Fax:

***RISK FACTORS**

☐ Y ☐ N	Patient is a healthcare worker, Position:	Facility/Employer Name:
☐ Y ☐ N	Close contact of ☐ Lab-confirmed COVID-19 case or ☐ Person with pneumonia or influenza-like illness **(Check one)**	
	Name of Case:	Date of Last Contact: / Nature of Contact:
☐ Y ☐ N	Member of a cluster of patients with acute respiratory illness/pneumonia of unknown etiology in which COVID-19 is being evaluated	
☐ Y ☐ N	History of being in a healthcare facility (as a patient or visitor): Facility name: _____ Date Visited: _____	
☐ Y ☐ N	Resident of long-term care facility or assisted living facility: Facility name: _____	
☐ Y ☐ N	Underlying health conditions **(circle)**: Asthma, COPD, renal disease, immunocompromised, diabetes, other:_____	
☐ Y ☐ N	Travel outside of Dallas County (international or domestic) or cruise within 2 weeks before illness onset:	
	Country/City/Cruise Name:	**Arrival Date:** / **Departure Date:**

CLINICAL HISTORY

*Hospitalized? ☐ N ☐ Y, Facility Name:

Admit Date:	Discharge Date:	Deceased Date (☐ N/A):	
***Date symptom onset:** _____ Symptoms Resolved? ☐ No ☐ Yes, date: _____		☐ *Asymptomatic (☐ N/A)	
***Symptoms (Check all applicable):**	☐ Fever >100F (38C)	☐ Chills	☐ Nausea or vomiting
	☐ Subjective fever (felt feverish)	☐ Muscle aches (myalgia)	☐ Headache
	☐ Cough (new or worsening)	☐ Runny nose (rhinorrhea)	☐ Abdominal pain
	☐ Shortness of breath (dyspnea)	☐ Sore throat	☐ Diarrhea (≥ 3/24hr period)
			Other, specify:

☐ Y ☐ N CHEST X-RAY	Date:	Results:
☐ Y ☐ N CHEST CT	Date:	Results:

LHD APPROVAL

☐ Y ☐ N Does patient meet testing criteria?** ***(Per DSHS, as of 4/17/20, patient must meet CDC priorities for testing, click here for priorities)

***Date Approved by LHD:**	***LHD Name:**	***LHD Contact Name:**
***LHD Contact Email:**		

LAB

Lab Contact Name:	*Lab Email:
Lab Phone:	*Lab Fax:
*Specimen Collection Date:	*Specimen source: ☐ NP (recommended) ☐ OP ☐ Other: _____

- *DO NOT WRITE BELOW THIS LINE* -

SPECIMEN

DCHHS LABORATORY RECEIPT

LAB #:	**DATE CHECKED IN:**	**DATE REPORTED:**	**DATE RESULTS FAXED:**

Date specimen received: _____ ☐ Cold ☐ Frozen ☐ Room temperature ☐ Satisfactory ☐ Unsatisfactory

COVID-19 PCR RESULTS

The CDC NCoV 2019 rRT-PCR Assay is only for use under the Food and Drug Administration's Emergency Use Authorization. Negative results do not preclude NCoV-2019 infection and should not be used as the sole basis for patient management decisions.

☐ No SARS-CoV-2 RNA detected	☐ Confirmed detection of SARS-CoV-2 RNA by RT-PCR
☐ Inconclusive for SARS-CoV-2 RNA by RT-PCR	☐ Specimen unsatisfactory due to: _____

FINAL REPORT:

A copy of this completed form must accompany the specimen **and** be faxed to DCHHS Epidemiology: (214) 819-1933 (OR sent by encrypted email to: Epidemiology@dallascounty.org). See submission instructions.

Rev. 3/27/2020 TD/WC

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