



Ohio Regional Testing Laboratories

SARS-CoV-2 Specimen Submission Form

Note: Fields marked with an asterisk (*) must be completed. Please print.
Approval required prior to submission to ODHL; Contact 614-995-5599

Section 1: Patient Information


Patient Name* (Last, First, MI)			Date of Birth* (mm/dd/year)	
Address		County	Patient Phone* Number	
City	State	Zip	Chart or* Patient ID#	
Race* <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Other: _____			Ethnicity* <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Sex* <input type="checkbox"/> Female <input type="checkbox"/> Male

Section 2: Submitter Information

Agency* Name			Contact* Name	
Address			Secure Fax* Number	
City	State	Zip	Phone* Number	

Section 3: Specimen Information (Complete all that apply)

Patient* Type <input type="checkbox"/> Resident <input type="checkbox"/> Staff	First Test?	Symptomatic*	Onset* Date	Collection* Date	Pregnant?
Hospitalized?	ICU?	Order* Date	Employed in Healthcare?	Agent* Suspected	
*Specimen Site					
<input type="checkbox"/> Blood-Specify (<input type="checkbox"/> Plasma <input type="checkbox"/> Whole)		<input type="checkbox"/> Respiratory, Upper-Specify Below:			
<input type="checkbox"/> Body Fluid-Specify Below: <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____		<input type="checkbox"/> Nasopharyngeal (NP) swab <input type="checkbox"/> Oropharyngeal (OP) swab <input type="checkbox"/> Other:			
<input type="checkbox"/> Serum-Specify (<input type="checkbox"/> Acute <input type="checkbox"/> Conv.)		<input type="checkbox"/> Respiratory, Lower-Specify Below:			
		<input type="checkbox"/> Sputum (<input type="checkbox"/> Induced <input type="checkbox"/> Expecterated)		<input type="checkbox"/> Bronchial Lavage (BAL)	
				<input type="checkbox"/> Tracheal Aspirate (TA)	

Specimen Barcode	*Insurance Information (if applicable)		Ordering Provider Information	
 v3.0.0	Name of Insured (Last, First, MI) <i>if not patient</i>		Name of Ordering Provider (Last, First) <i>if not the Contact</i>	
	Social Security Number:		Provider NPI	Provider Phone
	Name of Insurance Company:		Insurance Address	
	Insurance ID Number (if not SSN):		City: Zip: State:	
	Group ID Number:		ODH Facility License #*	ODH Outbreak#

Comments:	For Use by the Ohio Department of Health Laboratory Only	
	Date Received	Date Reported
	Fee Due MI	ODH LAB ID
	Exemption	