



# COVID-19 Supplemental Lab Form

This form must accompany specimens submitted to the Monterey County Public Health Laboratory for COVID-19 PCR testing. It is a supplemental form to accompany the standard Monterey County Public Health Laboratory Requisition Form. Both must be completed and submitted when requesting testing.

## Section A - Patient Details (Required):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Section B - Ethnicity (Required):

- African American/Black
- American Indian
- Asian/Pacific Islander
- Hispanic
- White
- Multiracial
- Other

## Section C - Vaccination History (Required):

Has the patient been vaccinated for COVID-19?  No  Yes

1st Dose Date: \_\_\_\_\_ Manufacturer: \_\_\_\_\_ Lot Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

2nd Dose Date: \_\_\_\_\_ Manufacturer: \_\_\_\_\_ Lot Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## Section D - Clinical Information (Required):

Symptomatic:  No  Yes, Date of Symptom Onset: \_\_\_\_\_

Symptoms:

- Cough, Productive
- Cough, Dry
- Sore Throat
- Nasal Congestion
- Fever, Measured \_\_\_\_\_ ° C / F
- Fever, Subjective
- Chills
- Malaise
- Myalgias
- SOB
- Hypoxia, O<sub>2</sub> Sat \_\_\_\_\_ % RA
- Chest Pain
- Thromboses
- Abd pain
- Loss of Sense of Smell
- Loss of Sense of Taste
- Nausea
- Vomiting
- Diarrhea
- Other: \_\_\_\_\_

## Section E - Public Health Risk Factors (Required):

- Close Contact with Case, Case Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Unable to isolate at home
- Homeless
- Travel: \_\_\_\_\_
- Occupation & Employer: \_\_\_\_\_

## PCR Testing Priorities (check the appropriate box – if left blank, assigned Priority 4):

Priority 1	<input type="checkbox"/>	Hospitalized patient
	<input type="checkbox"/>	Symptomatic health care worker or first responder
	<input type="checkbox"/>	Symptomatic resident of congregate living facility (SNF, correctional, etc.)
Priority 2	<input type="checkbox"/>	Close contact to laboratory-confirmed case
	<input type="checkbox"/>	Symptomatic individual >65 years of age or with chronic medical conditions
	<input type="checkbox"/>	Symptomatic essential worker (agriculture, grocery store, etc.)
Priority 3	<input type="checkbox"/>	Screening of asymptomatic residents of congregate living facilities prior to admission or re-admission to a congregate living facility
	<input type="checkbox"/>	Screening of asymptomatic health care workers and first responders
Priority 4	<input type="checkbox"/>	Symptomatic outpatient with no known risk
	<input type="checkbox"/>	Surveillance testing of asymptomatic individuals
	<input type="checkbox"/>	Pre-procedure screening of asymptomatic individuals

## Section F - Repeat Testing (complete only if specimen submitted is for repeat testing):

- Previous results were inconclusive by MCHD
- Correlation Study

## Section G - Whole Genome Sequencing (Complete only if WGS is requested):

Has MCHD Communicable Disease Unit authorized WGS testing?  No  Yes

If WGS is approved please complete Part H on next page and mark WGS order on requisition. To request WGS testing please contact CDU department for approval at (831) 755-4521.

# COVID-19 Supplemental Lab Form Continued

## **Section H - Details for Whole Genome Sequencing** (Required if WGS is Requested):

***Please provide previous SARS-CoV-2 results. Include the name of the testing laboratory, result, and dates tested:***

***Please provide reasons for requesting sequencing:***

- Possible reinfection case

*Date of previous lab confirmed SARS-CoV-2 infection/illness & type of test (PCR, antigen):*

- Outbreak investigation

*Outbreak Details:*

- Other

*Details:*

***Please provide treatment history (monoclonal antibodies, etc., admission to ICU):***

***Please provide detailed travel history (locations, dates, mode of travel, etc.):***

***Please confirm vaccination history is completed in section C. Vaccination history details are required for WGS.***