



COVID-19 Specimen Submission Form
 City of El Paso Department of Public Health Laboratory
 4505 Alberta Ave., 2nd Floor, El Paso, TX 79905-2818
 Ph: (915) 212-0438 Fax: (915) 212-0439 CLIA # 45D0660818

DPH Lab ID

Medical Director:
 Attilio Orazi, M.D., FRCPath.(Engl.)

SECTION 1. PATIENT INFORMATION (*REQUIRED)

Patient name-Last*		First*	M.I.	Phone ()	
Address-Number, street, apt #*			City**	State*	ZIP Code*
Date of birth* / /	Age	Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female		Medical Record#	
Does the patient live or has the patient recently traveled to an affected geographic area?*					<input type="checkbox"/> Yes <input type="checkbox"/> No
When did the patient travel to an affected geographic area?*					
/ / to / /		Place visited: _____			
Has the patient come in close contact with a person who is under investigation for COVID-19 while the person was ill?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient come in close contact with a laboratory-confirmed COVID-19 case while that case was ill?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient currently have or have they had (in the last 14 days) any of the following symptoms?*					
<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Other, Specify _____		
<input type="checkbox"/> Cough	<input type="checkbox"/> Chills	<input type="checkbox"/> Vomiting			
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Headache	<input type="checkbox"/> Abdominal pain	Date of symptom onset: / /		
Is the patient a health care worker?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in an affected geographic area?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which COVID-19 is being evaluated?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is/was the patient hospitalized?					<input type="checkbox"/> Yes Admit Date: _____ <input type="checkbox"/> No

SECTION 2. SUBMITTER INFORMATION (REQUIRED)**

Hospital/Facility name*		Ordering physician's name*			
Address-Number, street, apt #		City	County	State	ZIP Code
Contact*	Phone* ()	Fax* ()			

SECTION 3. SPECIMEN INFORMATION

Date of collection* / /	Time of collection* : <input type="checkbox"/> AM <input type="checkbox"/> PM
Test Requested <input checked="" type="checkbox"/> COVID-19 rRT-PCR	
Specimen source or type (2 upper respiratory, 1 lower respiratory)*	
<input type="checkbox"/> NP Swab <input type="checkbox"/> OP Swab <input type="checkbox"/> Sputum <input type="checkbox"/> BALFluid <input type="checkbox"/> Tracheal Aspirate	
Serum must be removed from the clot and transferred to a separate leak-proof container	
Samples that will arrive at the lab within 72 hours of collection can be stored at 2-8°C and shipped with cold packs.	

SECTION 4. SPECIMEN CONDITION (LABORATORY USE ONLY)

Specimen condition: Refrigerated (cold packs) Unacceptable _____

SECTION 5. rRT-PCR (LABORATORY USE ONLY)

<input type="checkbox"/> No COVID-19 detected by rRT-PCR <input type="checkbox"/> Inconclusive for COVID-19 by rRT-PCR <input type="checkbox"/> Presumptive Positive COVID-19 by rRT-PCR	Reference Range:
	No COVID-19 detected by rRT-PCR
<p><i>Results are for the presumptive identification of COVID-19 RNA. Presumptive positive COVID-19 and Inconclusive for COVID-19 specimens will be sent to the CDC for confirmatory testing. Positive results are indicative of active infection with COVID-19 but do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease. Negative results do not preclude the COVID-19 infection and should not be used as the sole basis for treatment or other patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological information. Testing with the COVID-19 rRT-PCR Diagnostic Panel is intended for use by trained laboratory personnel who are proficient in performing rRT-PCR assays. The CDC COVID-19 rRT-PCR Diagnostic Panel is only for use under a Food and Drug Administration's Emergency for Use Authorization.</i></p>	

Report Date: _____ Report Time: _____ AM PM Analyst: _____

CDC Testing Recommendations

1. Healthcare providers should **immediately** notify both infection control personnel at their healthcare facility and City of El Paso Department of Public Health (CEPDPH) Epidemiology in the event of a PUI for COVID-19. CEPDPH Epidemiologists that have identified a PUI should immediately contact CEPDPH Laboratory for testing and fill out a PUI case investigation form. Healthcare facilities will collect, store, and ship specimens appropriately to CEPDPH Laboratory. Testing for other respiratory pathogens should not delay specimen shipping to CEPDPH Laboratory. IF a PUI tests positive for another respiratory pathogen, after clinical evaluation and consultation with CEPDPH, they may no longer be considered a PUI. This may evolve as more information becomes available.

2. To increase the likelihood of detecting COVID-19 infection, CDC recommends collecting and testing multiple clinical specimens from different sites, including two specimens types - lower respiratory and upper respiratory. Additional specimen types may be collected and stored. Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset.

Criteria to Guide Evaluation of Persons Under Investigation (PUI) for COVID-19

Clinical Features

Epidemiologic Risk

Fever or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas (China, Iran, Italy, Japan, South Korea) within 14 days of symptom onset.
Fever with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization AND without alternative explanatory diagnosis (e.g., influenza)	AND	No source of exposure has been identified.

Contact Information

El Paso County

CEPDPH Epidemiology Program

Disease Reporting Hours:

24 hours a day / 7 days a week

915-212-6520

CEPDPH Laboratory

Specimen Delivery and Shipment

ATTN: DPH LRN Laboratory

4505 Alberta Ave. 2nd Floor

El Paso, TX 79905

Phone: 915-212-0438

Fax: 915-212-0439