COVID-19 LABORATORY FORM

Name of Reporting Centre	Specimen ID Number	Medical Record Number

1. Patient Information

First Name / Last Name	Sex	Date of Birth (dd/mm/yyyy)
First Name Last Name	☐Female ☐Male	/ /

Address in the last 14 days

House Number | Street Name | City/Settlement/Cay | Island | Country

Phone Numbers	Government ID
Mobile	Type ☐Passport ☐NIB
Home	Number
Work	Nationality

Email Address

Occupation

☐Construction ☐Financial services ☐Hospitality ☐Retail ☐Student ☐Uniformed branches
☐Clergy ☐Healthcare provider ☐Journalism/Broadcasting ☐Retired ☐Trade ☐Other
☐Education ☐Homemaker ☐Legal ☐Self-employed ☐Unemployed

Place of employment

2. Testing

Reason for Testing

☐Return from travel
☐For travel
☐Re-entry into Workplace
☐COVID-19 Symptoms
☐Exposure to Confirmed Case
☐Screening
☐Other

3. Symptomatology

COVID-19 symptoms in the last 14 days

☐Yes ☐No

Symptoms

☐Abdominal pain ☐Fatigue ☐Loss of taste
☐Chills ☐Fever ☐Loss of smell
☐Diarrhea ☐Headache ☐Shortness of breath
☐Dry cough ☐Myalgia ☐Vomiting

Date of Onset of Symptoms (dd/mm/yyyy) / /

4. Exposure History

Travel History

Domestic travel within the last 14 days? ☐Yes ☐No
If yes, where?

International travel within the last 14 days? ☐Yes ☐No
If yes, where?

Date of Domestic Travel (dd/mm/yyyy) / /

Date of International Travel (dd/mm/yyyy) / /

Contact with Known Case

Was there close contact with a known positive case within the past 14 days? ☐Yes ☐No
(Close contact is defined as contact for more than 15minutes and within less than 6feet)

Date of Exposure (dd/mm/yyyy) / /

5. Vital Status

☐Alive ☐Deceased

Date of Death (dd/mm/yyyy) / /

Disposition

Is/was the patient hospitalized? ☐Yes ☐No

If yes, where?

Date of Hospitalization (dd/mm/yyyy) / /

COVID-19 Vaccination Status

☐Not Vaccinated ☐Partially Vaccinated ☐Fully Vaccinated

Last COVID Vaccination Date (dd/mm/yyyy) / /

6. Laboratory data

What type of test was performed? ☐ Real-time PCR ☐ Rapid-Antigen Test

Sample Collection Method	Date Specimen Taken (dd/mm/yyyy)	Date Received by Lab (dd/mm/yyyy)	Result	Date of Result (dd/mm/yyyy)
☐ Nasopharyngeal swab ☐ Oropharyngeal swab ☐ Saliva	/ /	/ /		/ /

7. Comments

ADDITIONAL NOTES MAY BE WRITTEN OVERLEAF