COVID-19 POSITIVE TEST RESULT INTAKE FORM

Instructions: Please complete and submit one form per result. All fields on the left are required and all fields on the right are requested. **When completed, submit this form by fax to 509-764-2813.**

Date Submitted: Submitter name:

Section 1: Patient Information

REQUIRED	REQUESTED
Last name:	Age: _____ years
First name:	Race (select one): □ Unknown □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White □ Other Race
Middle name:	
Date of birth: _____ / _____ / _____	
Sex: □ Female □ Male □ Other	
Is the patient a resident or staff member of long-term care facility? □ Resident □ Staff □ Not applicable	
Phone number:	
Residential address:	
City:	Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown
State: WA / Zip code:	
County:	

Section 2: Reporting Facility and Ordering Provider Information

REQUIRED	REQUESTED
Reporting facility name:	Ordering provider name:
License number (if applicable):	
Facility address:	Ordering provider NPI (if applicable):
City:	
Zip code:	Ordering provider zip code:

Section 3: Test Information

REQUIRED	REQUESTED
Test name: □ Quidel Sofia 2 SARS Antigen FIA □ Abbott BinaxNOW COVID-19 Ag CARD □ BD Veritor System for Rapid Detection of SARS-CoV-2 □ LumiraDx SARS-CoV-2 Ag Test □ Other _____	Device identifier:
	Specimen ID:
	Test result date: _____ / _____ / _____
Specimen type: □ Nasal swab □ NP (nasopharyngeal swab	
Specimen collection date: _____ / _____ / _____	Test ordered date: _____ / _____ / _____
Test result: □ Detected □ Not detected □ Inconclusive	