DEPARTMENT OF HEALTH

Submit Sample(s) to:
MN Public Health Laboratory
Infectious Disease Lab
601 Robert St. N
St. Paul, MN 55155

Phone (651) 201-5200
Fax (877) 694-4502
Specimen Receiving (651) 201-4953
CLIA# 24D0651409

MDH Lab Use Only
Condition:
Ambient
Refrigerated
Frozen
Barcode Label

COVID-19 Surveillance Form

*Required Fields

***Purpose for submission:**

- ☐ Variant Surveillance
- ☐ Patient is **Hospitalized** with a positive SARS-CoV-2 test result
- ☐ Patient has suspected **Reinfection**
- ☐ Patient is **Vaccine Breakthrough** case (epi approval needed)
- ☐ Patient case meets criteria for **Monoclonal Antibody Failure**

Submitter

*Submitting Facility:

*Address:

City: State: Zip:

Name of Person Filling Out Form:

Phone # for questions with form/specimen:

Phone # for critical/alert values:

Ordering Provider:

Project Number: 2621

Patient

*Last Name:

*First Name: MI:

Address:

City: State: Zip:

County:

Patient MRN #:

*DOB (mm/dd/yyyy):

Sex: ☐ Male ☐ Female ☐ Other or Unknown

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other not listed
- ☐ Unknown/Not Provided

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Not Provided

Specimen

Sample ID:

*Date of Collection (mm/dd/yyyy):

Time of Collection (##:##): AM ☐ PM ☐

*Transport Media:
- ☐ VTM/UTM
- ☐ Saline

*Storage Condition Prior to Transport:
- ☐ Refrigerated
- ☐ Frozen

Other, specify:

*Source:
- ☐ Nasal Swab
- ☐ Nasopharyngeal Swab (NP Swab)
- ☐ Oropharyngeal Swab (OP Swab, Throat Swab)

Other, specify:

Test and Epidemiology Information

Collection Facility Information

*Collection Facility Name:

☐ Collection Facility is the same as Submitting Facility.
Skip to section - Patient Contact Tracing Information

Address:

City: State: Zip:

*Facility Type:
- ☐ Nursing Home
- ☐ Retirement Home
- ☐ Long Term Care Hospital
- ☐ Behavioral Health or Treatment
- ☐ Hospital or Clinic
- ☐ Correctional Facility
- ☐ Military Accommodation
- ☐ Sheltered Housing
- ☐ Other, specify:

*Patient Contact Tracing Information

- ☐ Patient is STAFF of collecting facility
- ☐ Patient is a RESIDENT of collecting facility
- ☐ Patient is a HEALTHCARE WORKER with direct patient contact
- ☐ Patient was vaccinated, date of final dose (mm/dd/yyyy):

Submitting Lab Test Result Information

Test Name:

Test Result:

***Ct Value** (if available):

Date of previous positive result (if applicable):

Monoclonal antibody treatment (if applicable):
- ☐ bamlanivimab
- ☐ casirivimab/imdevimab
- ☐ bamlanivimab/etesevimab

Submitting Laboratory - Specify Any Other Information or Comments: