MDH Infectious Disease Laboratory Influenza / SARS-CoV-2 Diagnostic Form Guidance

Submitter Information

Submitting Facility: Required. Facility sending in specimen/isolate. Results will only be faxed to the facility entered on this line. Full facility name, no abbreviations.

Address: Required. Address of the Facility sending in the specimen/isolate.

Name of Person Filling Out Form: MDH may need to contact you for additional information.

Phone # for questions with form/specimen: Phone number for contact with issues about missing/unreadable/mismatched data on the specimen or form.

Phone # for critical/alert values: Phone number for calling with critical result information. All results are still faxed to Submitting Facility.

Ordering Provider: Original medical professional ordering test, if applicable. First and last name are required. If first and last name are not given, provider will be listed as UNKNOWN.

Patient Information

Last name: Required (must match information on the specimen)

First name: Required (must match information on the specimen)

Address and County: Used for contact tracing by local public health, MDH and CDC

Patient Medical Record Number (MRN): Strongly preferred. Use unique number within submitting facility. Used to match patients within the system and link prior test results. Other unique patient identifiers are also acceptable. The Patient MRN# will appear on the report. **DO NOT** enter **submitter sample ID** here.

Date of Birth: Required. (must match information on the specimen).

Sex, Race and Ethnicity: Requested by CDC.

Specimen Information

Sample ID: Submitting lab accession or order number. If submitter is a correctional facility, long term care facility, or other non-clinical lab, this number may be omitted. The **Sample ID** will appear on the report if provided.

Collection Date: Required

Collection Time: Preferred, but not required for most tests. Will default to 00:00 AM if not provided.

Storage Condition Prior to Transport: Specimens should be stored refrigerated or frozen until transport. Do not store at ambient temperature.

NOTE: Transport Conditions: Specimens should be sent on **cold packs** for the duration of transport or kept **frozen with dry ice**.

Source: Select the source from the options provided. If not listed specify source in the "**Other**" field provided. Acceptable specimen types:

Upper respiratory tracts specimens:

- Nasopharyngeal (NP) swab
- Oropharyngeal (OP) swab (same as throat swab)
- Nasal mid-turbinate (NMT)
- Anterior nares specimen
- Nasopharyngeal NP and Orophayrngeal (OP) combined in the same container

Lower respiratory tract specimens:

- Sputum
- Bronchoalveolar lavage
- Tracheal aspirates

See COVID-19 Laboratory Guidance for additional specimen information if needed: https://www.health.state.mn.us/diseases/idlab/lisngs.html

Test and Epidemiology Information

Collection Facility Information: Required. Facility where specimen was collected. Full facility name, no abbreviations. If specimens go through an intermediary hospital lab, please list the name of the facility where the specimens were collected. **Results will only go to the submitting facility**. If submitting facility is the same as the collection facility, check that box and skip down to **Facility Type**.

Facility Type: Required. Please choose one of the CDC approved facility types listed below, if your facility type is not listed as a checkbox on the form, specify in **Facility Type, Other**.

Most Common Facility Types:

- Nursing Home
- Retirement Home
- Long Term Care Hospital
- Behavioral Health or Treatment
- Hospital or Clinic
- Correctional Facility (Penal institution)
- Military Accommodation
- Sheltered Housing

Other Approved Facility Types:

- Secure Hospital
- Orphanage
- Prison-based care site
- Substance abuse treatment center
- Boarding house
- Hospice
- Religious institutional residence
- Work (environment)

Patient Contact/Tracing Information: Required. This information is used by local public health, MDH and CDC.

Patient is a Resident of Collection Facility: Required. This information is used for contact tracing by local public health, MDH and CDC.

Patient is Healthcare Worker: Required. CDC definition includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or their infectious secretions and materials, including maintenance workers, trainees, and volunteers.

Does Patient have symptoms and Onset Date: Required. Onset date can be the date the first symptom was present. Symptoms as defined by CDC for COVID-19 including any of the following, check all that apply:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Hospitalization: Required**.** Specify if the patient is hospitalized and/or in ICU.

Is Patient Pregnant: Required if female. Choose **Yes**, **No**, **Unknown**.

Patient Phone Number, Email, and Preferred Language: Requested for contact tracing if necessary.

School or Child Care Attendance: Requested for contact tracing if necessary. List the name of any school or daycare the patient had contact with.

Employer and Occupation: Requested **if not** a resident of the Collection Facility. Used for contact tracing.

Minnesota Department of Health
Public Health Laboratory, Infectious Disease Laboratory
601 Robert Street North
PO Box 64899
St. Paul, MN 55164-0899
651-201-5200
health.mdhlab@state.mn.us
www.health.state.mn.us/about/org/phl/topics/index.html

08/2020

To obtain this information in a different format, call: 651-201-5200.