CLIENT #_____

KDHE lab use only

Kansas Department of Health and Environment COVID-19 Specimen Submission Form

KDHE lab use only

- **Ensure all information is completed for all patients.**
- This form must be submitted with the specimen to KHEL
- This form is only for use when requesting SARS-CoV-2 testing at KHEL.

PROVIDER INFORMATION

Facility Name: Barton County Health Dept **KHEL Facility ID:** 14074 **Clinician Name:** Dr. Pike

Facility Address: 1300 Kansas Ave; Ste B **City:** Great Bend **State:** KS **ZIP:** 67530

Existing KHEL facilities can contact KHEL Customer Service to change/verify report method (785) 296-1620 | kdhe.khel_help@ks.gov

NEW KHEL FACILITY ONLY — COMPLETE REPORT DELIVERY OPTIONS BELOW

Lab report delivery preference: ☒ **Fax #:** (620) 793-1903 ☐ **Secure Email:** _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle:** _____

DOB: _____ **Mobile Phone:** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____
NO PO BOX – PHYSICAL ADDRESS ONLY

County of residence: _____ **Parent/Guardian Name:** _____

Sex: ☐ Male ☐ Female **Ethnicity:** ☐ Non-Hispanic ☐ Hispanic ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

SPECIMEN INFORMATION

Collection Date: _____ **Time:** _____ AM/PM **Date test ordered:** _____

Specimen type: ☐ Nasal swab (mid turbinate) ☐ Nasal swab (anterior nares) ☐ Nasopharyngeal swab ☐ Oropharyngeal (throat) swab ☐ Blood/Serum

Test ordered: ☒ RT-PCR ☐ Antigen ☐ Serology **Collected by:** ☒ healthcare staff ☐ Self-collected

SYMPTOMS AND EXPOSURE INFORMATION

Symptom onset date of first symptom: _____ ☐ Asymptomatic (no symptoms)

☐ Fever (subjective/or measured:_____ °F/°C) ☐ Cough ☐ Shortness of Breath ☐ Difficulty breathing

☐ Sore Throat ☐ Loss of smell/taste ☐ Rigors or chills ☐ Myalgia or muscle aches ☐ Headache

☐ Malaise or feeling very tired ☐ Pneumonia ☐ Diarrhea ☐ Nausea/vomiting ☐ Congestion/runny nose

☐ Acute Respiratory Distress Syndrome

Immunocompromised/Chronic Condition? Yes, specify: _____ ☐ No

Exposure? _____