NEW YORK STATE DEPARTMENT OF HEALTH

Wadsworth Center

Emergency Use Infectious Diseases Requisition / COVID-19

Please send specimen(s) to: New York State Department of Health, Wadsworth Center

Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208

For more information, go to:

https://www.wadsworth.org/programs/id

Patient Demographics and Requesting Provider

*required information

Last name or Patient code* | First name* | MI | DOB* | Sex*

___ | ___ | ___/___/____ | ☐ Male ☐ Female ☐ None Assigned

Permanent Street Address | Facility of Residence (if applicable) | City | State* | Zip Code

NYS County of Residence* | Patient Telephone Number ( ) – | Patient Reference Number | NYS DOH Outbreak Number | CDESS Case Number

Race (select one or more) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current gender identity ☐ Male (M) ☐ Female (F) ☐ Transgender M-to-F ☐ Transgender F-to-M ☐ Nonconforming ☐ Other(specify)_____

Employer | Work Street Address | City | State | Zip Code

Occupation | Work Telephone Number ( ) –

Name- Health Care Provider (HCP) | National Provider Identifier (NPI):

HCP Telephone Number ( ) – | Zip Code for HCP

Submitting Facility (Laboratory report will be sent to this address)

*required information

Name* _____ Laboratory PFI _____

Address* _____ NPI _____

Attention to / Contact Person _____ Telephone Number* ( ) –

Specimen Information

*required information

Collection Date*: ___/___/___ Time Collected (if applicable): _____ Date of Symptom(s) Onset: ___/___/_____

Source(s)* _____ Autopsy ☐

Specimen submitted on/in (specify media/preservative/cell line) _____ Submitter's Specimen Identifier(s) _____

Laboratory Examination Requested

☐ Molecular Virology _____

☐ Serology _____

☐ Other _____

Clinical History

COVID-19 First Test* ☐ Yes ☐ No ☐ Unknown Pregnant (trimester) _____

☐ Health Care Worker ☐ Donor Screening ☐ Resident in a congregate care setting _____

Relevant Exposure: ☐ Contact w/Known case ☐ Travel Hospitalized: ☐ Yes ☐ No ☐ ICU Hospital Name _____

Exposure detail: Date ___/___/_____

Relevant Treatment: Date: / / Relevant Immunization: Date: / /

**Symptoms – select severity: ☐ Asymptomatic ☐ Mild ☐ Severe ☐ Unknown

Notes

_____

_____

_____