



Mercy Health Lorain

3700 Kolbe Road
Lorain, Ohio 44053

Ordering Provider: Malar, Kathleen, CNP

Patient Name: _____
(Last) (First) (MI)

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Sex:** M F _____

Race: American Indian or Alaska Native (NAAM) Asian (ASIAN)
 Black or African American (AFAM) Hispanic or Latino (HISP)
 Native Hawaiian or Other Pacific Islander White (WHITE) Other _____

Collection Date: ____/____/____ **Collection Time:** ____:____ **Collector:** _____
(First Initial and Full Last Name)

Requested Test: ACOV (SARS-CoV-2,NAA)

Specimen Type (check one): **Anterior Nares (AN)** _____
Nasopharyngeal (NP) _____
Oropharyngeal (OP) _____

Questions Required by ODH:

1. First test (Yes / No / Unknown)
2. Employed in healthcare? (Yes / No / Unknown)
3. Symptomatic as defined by CDC? Yes No
4. Hospitalized? Yes No
5. ICU? Yes No
6. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting): (Yes / No / Unknown)
7. Pregnant? (Yes / No / Unknown)

Collector Instructions:

- Collect specimen using the provided AN, NP or OP swab with saline media.
- Label media tube with full patient name and date of birth.
- Place labeled media tube with swab into small biohazard bag and seal, place corresponding requisition (this form) in pouch of biohazard bag.

Lab Use Only:

- Register in LIS only. EPIC registration not required. Ward: LCLCS