SARS-CoV-2 Laboratory Requisition and PUI Evaluation Form

03/13/2020 v2.

SOUTH DAKOTA DEPARTMENT OF HEALTH

South Dakota Public Health Laboratory
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Lab Use Only

Facility_____ Phone # _____

Address_____ Physician_____

City_____

Patient Information: Patient ID_____

Patient name: (Last)_____(First)_____ MI_____

Patient Address _____Date of Birth ____/_____/_____ Sex ___ Race _____

City_____ State_____ Zip Code _____ Medicaid/Medicare #_____

Specimen Collection Date: ____/_____/_____ **Specimen Source:** ☐ Nasopharyngeal (NP) ☐ Sputum

Patient Information:

Date of Onset ____/____/_____

Is the Patient Symptomatic? ☐ **Yes** ☐ **No**

Please indicate patient symptoms:

- ☐ Fever, highest: _____
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Pneumonia
- ☐ ARDS

Is the patient a healthcare worker, first responder, or active military or National Guard? ☐ **Yes** ☐ **No**

Is the patient hospitalized ☐ **Yes** ☐ **No**

Does the patient live in an institutional setting (e.g., long term care, assisted living, corrections)? ☐ **Yes** ☐ **No**

Please indicate if the patient has one or more of the following preexisting conditions:

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Immunosuppression
- ☐ Diabetes
- ☐ Pregnancy
- ☐ Other

***Please attach or include any relevant results. (i.e. influenza, RSV, RPP, etc.)

Asymptomatic Individuals Will NOT Be Tested