**Tests Requested**

<table>
<thead>
<tr>
<th>Tests Requested</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Was patient prescreened for flu?</td>
<td></td>
</tr>
<tr>
<td>Result of prescreening:</td>
<td></td>
</tr>
<tr>
<td>Respiratory Panel</td>
<td></td>
</tr>
<tr>
<td>Herpes/VZV</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Norovirus</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**CLINICAL DATA**

- **Purpose of request:**
  - [ ] diagnostic (give onset)
  - [ ] immune status
  - [ ] antibody status
  - [ ] Deceased
  - [ ] Other

**Date of Onset:**

- **Symptoms:**
  - [ ] YES
  - [ ] NO

- [ ] Fever
- [ ] Neurological
- [ ] Headache
- [ ] Respiratory
- [ ] Gastrointestinal
- [ ] Fatigue
- [ ] Rash
- [ ] Lesions
- [ ] Other

**Specimen Source / Date Collected**

- [ ] Throat Swab
- [ ] NP Swab
- [ ] OP Swab
- [ ] Nasal Swab
- [ ] Genital Swab
- [ ] CSF
- [ ] Stool
- [ ] Serum
- [ ] Other

<table>
<thead>
<tr>
<th>Immunizations / Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>MMR</td>
</tr>
<tr>
<td>Influenza</td>
</tr>
<tr>
<td>Varicella</td>
</tr>
<tr>
<td>COVID</td>
</tr>
</tbody>
</table>

**Contacts / Recent Travel**

- Tick bite
- Mosquito bite
- Community
- Other
- Travel

**Testing approved?**

- COVID Sequencing

- [ ] Yes
- [ ] No

**Hospitalization**

- [ ] Yes
- [ ] No

**Pregnant**

- [ ] ________weeks

**DLS Laboratory Findings**