DEPARTMENT OF HEALTH

Submit Sample(s) to:
MN Public Health Laboratory
Infectious Disease Lab
601 Robert St. N
St. Paul, MN 55155

Phone (651) 201-5200
Fax (651) 201-5070
Specimen Receiving (651) 201-4953
CLIA# 24D0651409

MDH Lab Use Only
Condition:
Room Temp
Frozen
Cool Pack
Barcode Label

COVID-19 Special Request Form

*Required Fields

***Purpose for submission:**

- [x] Variant Surveillance
- [ ] Patient is **Hospitalized** with a positive SARS-CoV-2 test result
- [ ] Patient has suspected **Reinfection**
- [ ] Patient is **Vaccine Breakthrough** case (epi approval needed)
- [ ] Patient case meets criteria for **Monoclonal Antibody Failure**

Submitter

*Submitting Facility:

*Address:

City: State: Zip:

Name of Person Filling Out Form:

Phone # for questions with form/specimen:

Phone # for critical/alert values:

Ordering Provider:

Project Number: 2621

Patient

*Last Name:

*First Name: MI: J

Address:

City: State: Zip:

County:

Patient MRN #:

*DOB (mm/dd/yyyy):

Sex: [ ] Male [ ] Female [ ] Other or Unknown

Race:
- [ ] American Indian/Alaska Native
- [ ] Asian
- [ ] Black
- [ ] Native Hawaiian/Pacific Islander
- [ ] White
- [ ] Other not listed
- [ ] Unknown/Not Provided

Ethnicity:
- [ ] Hispanic/Latino
- [ ] Non-Hispanic/Latino
- [ ] Not Provided

Specimen

Sample ID:

*Date of Collection (mm/dd/yyyy):

Time of Collection (##:##): AM [ ] PM [ ]

*Transport Media:
- [ ] VTM/UTM
- [ ] Saline

*Storage Condition Prior to Transport:
- [ ] Refrigerated
- [ ] Frozen

Other, specify:

*Source:
- [ ] Nasal Swab
- [ ] Nasopharyngeal Swab (NP Swab)
- [ ] Oropharyngeal Swab (OP Swab, Throat Swab)

Other, specify:

Test and Epidemiology Information

Collection Facility Information

*Collection Facility Name: CentraCare Rice Memorial Hospital

- [ ] Collection Facility is the same as Submitting Facility. Skip to section - Patient Contact Tracing Information

Address:

City: State: Zip:

*Facility Type:
- [ ] Nursing Home
- [ ] Retirement Home
- [ ] Long Term Care Hospital
- [ ] Behavioral Health or Treatment
- [ ] Hospital or Clinic
- [ ] Correctional Facility
- [ ] Military Accommodation
- [ ] Sheltered Housing
- [ ] Other, specify:

*Patient Contact Tracing Information

- [ ] Patient is STAFF of collecting facility
- [ ] Patient is a RESIDENT of collecting facility
- [ ] Patient is a HEALTHCARE WORKER with direct patient contact
- [ ] Patient was vaccinated, date of final dose (mm/dd/yyyy):

Submitting Lab Test Result Information

Test Name:

Test Result:

***Ct Value** (if available):

Date of previous postitive result (if applicable):

Monoclonal antibody treatment (if applicable):
- [ ] bamlanivimab
- [ ] casirivimab/imdevimab
- [ ] bamlanivimab/etesevimab

Submitting Laboratory - Specify Any Other Information or Comments: