



**SUB-NATIONAL LABORATORY FOR EMERGING AND RE-EMERGING INFECTIOUS DISEASES (EREID)**

LABORATORY REFERRAL REQUEST FORM FOR COVID-19				
Completely fill-out data in this form.				
<b>I. PATIENT INFORMATION:</b> (to be filled-out by requisitioner)		<b>SPECIMEN NO.</b>		
<b>Name:</b> (First, Middle, Last)		<b>HOSPITAL NO.</b>		
<b>Address:</b> (Street, Barangay, District, Municipality, Province, Region)		<b>Date of Birth:</b> ____/____/____ (MM / DD / YYYY)		<b>SEX:</b> ____ <b>M</b> ____ ____ <b>F</b> ____
		<b>AGE:</b> ____/____ (YY / MM)		
<b>Clinical Impression:</b>  <input type="radio"/> <b>PUI</b> <input type="radio"/> <b>PUM</b> <input type="radio"/> <b>Confirmed</b>		<b>Location/Classification:</b> ____ Referral ____ OPD ____ In-patient		<b>Date of Admission:</b> ____/____/____ (MM / DD / YYYY)
		<b>Date of Onset of Illness:</b> ____/____/____ (MM / DD / YYYY)		
<b>II. REQUISITIONER INFORMATION:</b> (To be filled-out by requisitioner)				
<b>Details of Requesting Institution:</b> <b>Name of facility:</b> _____ <b>Address:</b> _____ <b>Tel. No.</b> _____ <b>Mobile No.</b> _____ <b>Institution's E-mail address:</b> _____ (Note: Results will be reported based on DOH and SLH-SNL institutional guidelines)		<b>Name in print and signature of requesting physician:</b>     <b>Specimen Collected by:</b> (name and signature)		
<b>III. SPECIMEN INFORMATION</b> (to be filled-out by referring institution)		<b>Was the specimen stored prior to transport in:</b> <input type="radio"/> room temperature <input type="radio"/> refrigerator <input type="radio"/> freezer		<b>Instructions to referring institution/facility:</b> (to be filled-out by SLH-SNL)
<b>Specimen Type:</b> (please check one)	<b>Date Collected:</b>	<b>Specimen Evaluation:</b> (to be filled-out by SLH-SNL)		
____ NPS and OPS in single UTM/VTM	<b>Time Collected:</b>	____ <b>ACCEPTABLE</b>		
____ NPS only in UTM/VTM	<b>Order of Specimen:</b> <input type="radio"/> <b>1st</b> <input type="radio"/> <b>2nd</b> <input type="radio"/> <b>3rd</b> <input type="radio"/> <b>4th</b>	____ <b>NOT ACCEPTABLE</b> reason/s:		
____ OPS only in UTM/VTM				
____ Bronchoalveolar Lavage (BAL)				
____ Sputum				
____ Endotracheal aspirate				
<b>Date and Time Received and Name of SLH staff</b> (name in print and signature)				
<b>REMARK/S:</b>				
For inquiries, contact SLH Department of Laboratories Tel. No. (02)53102005 or send an e-mail to: <a href="mailto:slhlab.covid19@yahoo.com">slhlab.covid19@yahoo.com</a>				