Long Term Care Facility COVID-19 Reporting Form

Ordering Facility Name:

Sender CLIA Number:

Ordering Facility Address:

Street:

City:

State:

Zip code:

Phone Number:

Contact:

Test Result Date:

Patient Information:

First Name:

Last Name:

Date of Birth:

Sex:

Patient Address:

Street:

City:

State:

Zip code:

County:

Phone Number:

Specimen Collection Date:

Specimen Source:

Test Result Description:

Device Identifier:

Result:

Result Notes: