NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

# Emergency Use Infectious Diseases Requisition / COVID-19

**Please send specimen(s) to:** New York State Department of Health, Wadsworth Center
Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208

For more information, go to:
https://coronavirus.health.ny.gov/home

## Patient and Provider

*required information

Last name* | First name* | MI | DOB* / / | ☐ Male ☐ Female ☐ Other

Permanent Street Address* | Facility of Residence (if applicable) | City* | State* | Zip Code*

NYS County of Residence* | Patient Telephone Number* ( ) – | Patient Reference Number | NYS DOH Outbreak Number | CDESS Case Number

Employer* | Work Street Address* | City* | State* | Zip Code*

Occupation* | Work Telephone Number* ( ) –

*Race (Select one or more) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

*Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Name - Health Care Provider (HCP) : | National Provider Identifier (NPI):

HCP Telephone Number: ( ) – | Zip Code for HCP:

## Submitting Facility

*required information

Name* | Laboratory PFI

Address* | NPI

Contact Person* | Phone* ( ) –

## Specimen Information

*required information

Collection Date*: / / | Time Collected (if applicable): | Pregnant (trimester): _____ | ☐ Autopsy

First Test* ☐ Yes ☐ No ☐ Unknown | Symptoms*: ☐ Asymptomatic ☐ Mild ☐ Severe ☐ Unknown | Date of Symptom(s) Onset: / /

Specimen Type* | Specimen submitted in (specify media/preservative) | Submitter's Specimen Identifier(s)

☐ Health Care Worker ☐ Donor Screening ☐ Resident in a congregate care setting

Relevant Exposure: ☐ Travel ☐ Contact w/ Known Case | Hospitalized: ☐ Yes ☐ ICU ☐ No | Hospital Name _____

Exposure detail: Date: / /

## Test Requested

☐ Molecular Virology
☐ Serology
☐ Other

## Notes