GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
761 South Marine Corps Drive, Tamuning, Guam 96913
Telephone: (671) 988-4788/735-7136

(PLEASE PRINT LEGIBLY)

☐ Walk-in #_____

☐ Drive-Thru #_____

GPHL LABORATORY NUMBER

DATE RECEIVED

ORDERING/PRIMARY PHYSICIAN: Teofila Cruz

ADDRESS: DPHSS NRCHC

Street: 520 WEST SANTA MONICA AVENUE

City: DEDEDO State: GUAM

Phone No.: (671) 635-7492 Zip Code: 96929

SUBMITTING LABORATORY:

ADDRESS:

Street:

City: State:

Country: Zip Code:

Phone No.:

I. PATIENT IDENTIFICATION

LAST NAME | FIRST NAME AND MIDDLE INITIAL

RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)

Street:

City: Zip Code:

PHONE NO.:

Cell/Mobile: Home: Work:

OCCUPATION	ETHNICITY (e.g. Chamorro, Filipino, etc.)	DATE OF BIRTH	SEX

CLINICAL DIAGNOSIS

DATE OF ONSET

LABORATORY EXAMINATION REQUESTED: COVID-19/SARS-COV-2

CATEGORY OF AGENT SUSPECTED

SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN
   - ☑ HUMAN
   - ☐ OTHER (Specify):

2. ORIGINAL MATERIAL
   - TYPE OF SPECIMEN (SPECIFY SITE OF COLLECTION): NASOPHARYNGEAL
   - DATE AND TIME OF COLLECTION:
   - TRANSPORT MEDIUM: VIRAL TRANSPORT MEDIA
   - SWABBED BY RN / LPN (PRINT NAME):

3. SEROLOGY OF SPECIMEN
   - COLLECTION DATE:
   - ☐ ACUTE (S1):
   - ☐ CONVALESCENT (S2):
   - ☐ S3:
   - ☐ S4:
   - ☐ OTHER (Specify):

4. SEROLOGY OF SPECIMEN
   - ☐ PURE ISOLATE
   - ☐ MIXED CULTURE
   - ☐ OTHER (Specify):
   - DATE OF ORIGINAL CULTURE:
   - PRIMARY ISOLATON MEDIA:
   - COLLECTON SITE OF ORIGINAL SPECIMEN:
   - DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED:
   - SUSPECTED IDENTIFICATION:
   - OTHER ORGANISMS FOUND:
   - OTHER INFORMATION:

9:00 a.m. Wednesday, January 13, 2021

III. CLINICAL HISTORY

1. CLINICAL SIGNS AND SYMPTOMS
   - ☐ FEVER
   - ☐ EXANTHEMA (Specify Type):
   - ☐ RESPIRATORY SIGNS:
   - ☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT:
   - ☐ GASTROINTESTINAL INVOLVEMENT:

2. ADDITIONAL INFORMATION
   - TRAVEL HISTORY: ☐ YES ☐ NO
   - SPECIFY:
   - IMMUNIZATIONS:
   - ANTIBIOTIC THERAPY:

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

DATE OF REPORT:_____

The instrumentation used to conduct the test has significant sensitivity. Nevertheless few negative results should be treated with caution. Patient follow up and repeat testing, if clinically indicated, are recommended.

Patient Last Name: _____ **Patient First Name:** _____
Date of Birth: _____

COVID-19 Form for Mass Screening

Date of onset: _____ (***if symptomatic***)

During this illness, did the patient experience any of the following symptoms?

SYMPTOMS	YES	NO
Fever >100.4F (38C)		✔
Subjective fever (felt feverish		✔
Chills		✔
Muscle aches (myalgias)		✔
Runny nose		✔
Sore throat		✔
Cough (new or worsening)		✔
Shortness of breath		✔
Nausea or vomiting		✔
Headache		✔
Abdominal pain		✔
Diarrhea		✔
Loss of sense of smell or taste or appetite		✔
Congestion		✔
Fatigue/weakness		✔
Rash		✔
Other (specify):		✔

Does the patient have any pre-existing medical conditions?

CONDITION	YES	NO
Chronic lung disease (asthma, emphysema, COPD)		✔
Diabetes mellitus		✔
Cardiovascular disease		✔
Hypertension only (high blood pressure)		✔
Chronic renal disease (ESRD/CRI)		✔
Chronic liver disease		✔
Immunocompromised condition (cancer, chemo, lupus, HIV etc).		✔
Neurological/neurodevelopmental/intellectual disability		✔
Hepatitis		✔
Other (specify):		✔
Former smoker		✔
Current smoker		✔

Contact with another lab-confirmed COVID-19 patient? Yes ☐ No ☐

Type of Contact: ☐ **Household** ☐ **Community** ☐ **Workplace** ☐ **Healthcare**

Previous COVID-19 testing? Yes ☐ No ☐ If *"Yes"*, Date of collection: _____

Name of Interviewer: Last _____ **First** _____

Date of Interview: _____