GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
761 South Marine Corps Drive, Tamuning, Guam 96913
Telephone: (671) 300-9085/9096/9097/9098 Fax: (671) 300-9989

(PLEASE TYPE INFORMATION AND OR PRINT LEGIBLY)

GPHL LABORATORY NUMBER

DATE RECEIVED

ORDERING/PRIMARY PHYSICIAN: Felix T. Cabrera, M.D. or designee

ADDRESS: TIYAN OUTREACH

Street: 520 WEST SANTA MONICA AVENUE

City: DEDEDO State: GUAM

Country: USA Zip Code: 96929

Phone No.: (671) 635-7525

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:

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

CLINICAL DIAGNOSIS

DATE OF ONSET

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

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:

COLLECTED BY (PRINT NAME): RN/LPN/CNA

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:

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:

IMMUNIZATIONS: ☐ YES ☐ NO
- ☐ Pfizer 1st Dose 2nd Dose
- ☐ Moderna 1st Dose 2nd Dose
- ☐ Janssen Single Dose

ANTIBIOTIC THERAPY:

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

Assay:

Result:

DATE OF REPORT:_____ REFERENCE VALUES: NEGATIVE OR NOT DETECTED

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

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 Testing/Outreach/Mass Screening

Date of onset: _____(*if symptomatic*) Date of travel:_____(*if history stated)*

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	☐	☐
Current Smoker	☐	☐
Former smoker	☐	☐
For Females, is patient currently pregnant?	☐	☐
Other (specify):	☐	☐

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:_____ Result:_____

Name of Interviewer: Last _____ First _____

Date of Interview: _____