ARKANSAS
DEPARTMENT OF HEALTH
PUBLIC HEALTH LABORATORY
201 South Monroe
Little Rock, AR 72205

COVID-19 Test Request Form

Patient Information (** Required fields)

Last Name**	First Name**	Middle initial

Address**	Phone Number**	MRN

City**	State**	Zip**	County of Residence**

Race**

○ White ○ Black or African American ○ American Indian/ Native Alaska ○ Asian ○ Native Hawaiian/ Pacific Islander ○ Other

Ethnicity**	Sex**	Date of Birth**
○ Hispanic ○ Non-Hispanic ○ Unknown	○ Male ○ Female	

Epidemiology Information (Mark all that apply)

Date of Onset (MM/DD/YY):

☐ Fever ☐ Cough

☐ Sore throat ☐ Shortness of breath

☐ Chills ☐ Headache

☐ Muscle aches ☐ Vomiting

☐ Abdominal pain ☐ Diarrhea

☐ New loss of taste ☐ New loss of smell

☐ None/Asymptomatic

Contact with confirmed case of COVID-19?
○ Yes ○ No ○ Unknown

Health Care Worker? ○ Yes ○ No ○ Unknown

Pregnant? ○ Yes ○ No ○ Unknown

Is this the patient's first COVID-19 test?
○ Yes ○ No ○ Unknown

Patient Hospitalized? ○ Yes ○ No ○ Unknown

Is this patient in ICU? ○ Yes ○ No ○ Unknown

Patient has underlying medical conditions?
○ Yes ○ No ○ Unknown

Was other testing performed? ○ Yes ○ No ○ Unknown

If Yes, indicate the results _____

Is this patient a resident in a congregate care setting (nursing home, homeless shelter, prison facility, etc.)?
○ Yes ○ No ○ Unknown

Submitter Information (** Required fields)

Submitter ID or #** (if you do not have one, leave blank)	Submitter's/Facility's Name**

Submitter's/Facility's Address**	City**	State**	Zip**

Contact Person**	Phone Number**	Fax Number	Email

Test Requisition Information(**Required fields)

Date Collected**		Time Collected**	

Specimen Type**

● Nasal Swab ○ NP Swab

Requestor's Name**	NPI (national provider identifier)	Requestor's Phone Number**
Naveen Patil, MD		

○ = Select only ONE; ☐ = Check ALL that apply; ** = Required fields; For times, use Military format HH:MM

Fill out this form in its entirety. Type and print a completed form with each specimen.

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INSURANCE INFORMATION (Check appropriate box):

☐ **No Insurance – by marking this box, the patient attests that they do not have healthcare coverage.**

☐ **Medicaid/ARKids Number:** _____

☐ **Medicare Number:** _____

☐ **Insurance Company Name:** _____

Member ID/Policy #: _____

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Policy Holder Date of Birth: _____

Policy Holder's Employer Name: _____

Social Security # or Driver's License #:

Email Address: _____

My signature below indicates I have read, understand and agree to the following:

I authorize the release of any medical information necessary to process insurance claim(s).

I authorize and request payment of medical benefits directly to the Arkansas Department of Health.

I acknowledge that there may be notification of either positive or negative COVID test results via text messaging.

I give consent to the State/Local Health Department and its staff for the individual named as patient on the front of this form to be tested for COVID-19.

Patient/Parent/Guardian Signature:

Please Sign Here: _____