Mississippi State Department of Health

Mississippi Public Health Laboratory
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CLIA #: 25D1096223

Surveillance

SARS-CoV-2 Enhanced Surveillance Submission Requisition

Please make sure the information on the form is legible and complete.

SUBMITTER INFORMATION

Patient ID Number		
Submitting Facility Name		
Street Address		
City	**State**	**Zip**
Phone Number		

PATIENT INFORMATION

PATIENT NAME (Last)	**First**	**MI**	**Suffix**
County of Residence	**Date of Birth**		
Address			
City	**State**	**Zip Code**	
Phone Number			

Specimens Submitted
(Please only submit one specimen type per patient)

- ☐ Nasopharyngeal swab (NP)
- ☐ Oropharyngeal swab (OP)
- ☐ Nasal mid-turbinate (NMT)
- ☐ Anterior nares (NS) swab

RACE

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Pacific Islander/ Hawaiian
- ☐ White/ Caucasian
- ☐ Other

Test Requested:

- ☐ SARS-CoV-2 surveillance characterization

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

SEX

- ☐ Male
- ☐ Female

Date of Collection:

Date of SARS CoV-2 positive test (yyyy/mm/dd):

Type of Test: ☐ **Antigen** ☐ **PCR** ☐ **TMA**

C. Indication for SARS-CoV-2 Variant (VOC) Screening: Select the correct submission criteria listed below:

☐ Suspected re-infection identified by PCR testing.
Date of the original positive test? ____/_____/____ (mm/dd/yyyy) Type of Test: ☐ Antigen ☐ PCR ☐ TMA

☐ Multitarget PCR assay with S gene dropout (S gene negative) and other gene target(s) positive with Ct ≤30.

☐ Vaccinated individuals with subsequent laboratory-confirmed SARS-CoV-2 infection ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine.
Date of last Dose ____/_____/____ (mm/dd/yyyy) Vaccine Name: _____

☐ Known or suspected outbreak event (minimum of 3 specimens and maximum of 5 specimens).

☒ MSDH weekly surveillance request (up to 5 per week per facility).

Instructions for Form 1198, SARS-CoV-2 Surveillance Submission Requisition

Purpose
To collect submitter information, patient demographics and specimen information for specimens submitted for SARS-CoV-2 Surveillance testing.

Instructions:
Submitter Information- Left hand side of requisition
Record all requested information
Patient ID Number: Enter the submitter's patient identification number.
Submitter Name: Enter the submitting facility's full name.
Street Address: Enter the submitting facility's street address
City: Enter the submitting facility's city
State: Enter the submitting facility's state
Zip: Enter the submitting facility's zip code
Phone Number: Enter the submitting facility's phone number
Contact Name: Enter the name of the submitting facility's contact if applicable
Contact: Enter the phone number of the submitting facility's contact if applicable

Patient Information – Right hand of requisition
Patient Name- Enter the patient's LAST NAME, FIRST NAME AND MIDDLE INITIAL in sequence. The spelling of the name on the laboratory slip and the specimen container/tube must be identical. **Name listed must be legal name; DO NOT use nicknames**.

County of Residence- Enter the county where the patient currently resides (Hinds, Rankin, etc).
Date of Birth- Provide in MM/DD/YY format.
Address - Enter the complete address where the patient currently resides.
City - Enter the name of the city in which the patient resides.
State - Enter the state in which the patient resides
Zip Code - Enter the Zip Code of the patient's address.
Phone Number – Enter patient's telephone number including area code.
Specimen Type: Submit a NP swab and an OP swab for each patient. If patient has a productive cough, submit one Lower Respiratory Specimen in addition to NP and OP swabs. Provide the Date of collection in MM/DD/YY format
Test Requested: Check the box by the appropriate test requested.
Date of Collection: **Provide** in MM/DD/YY format.
Date of SARS-CoV-2 Positive Test: **Provide** in MM/DD/YY format.
Type of Test: Check the box associated with the type of test performed to confirm patient was positive.
Race – Check the box associated with the patient's race
Ethnicity- Check the appropriate box
Sex- Check the appropriate box (male or female)
Indication for SARS-CoV-2 Surveillance Testing: Check the appropriate reason for submission. Provide all applicable information requested.

Office Mechanics and Filing – This form must accompany each patient for whom specimens are submitted to the MSDH Laboratory. A copy should be retained by the submitter as documentation of submission. Test results will be reported via computer generated report and forwarded to the submitter.

Retention Period – The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations.