WASHINGTON STATE COVID-19 POINT OF CARE TEST RESULT REPORT FORM

Instructions: Complete one form for each positive result. Please write clearly and put only one character in each box (including spaces). Submit Page 1 by fax to the Washington State Department of Health at (206) 512-2126. A description for each field in the Report Form is provided on Page 2.

Submitter name: | Date submitted (MM/DD/YYYY): / /

Section 1: Testing Facility and Ordering Provider Information

Facility name:

Ordering provider name (first and last):

NPI (National Provider Identifier): | CLIA number:

Ordering facility or provider address:

City: | State: | Zip code:

County: | Phone: | ext.

Section 2: Patient Information

Last name: | First name: | Middle Initial:

Sex at birth: □ Female □ Male □ Neither/Other □ Unknown | Date of birth (MM/DD/YYYY): / / | Age: years

Patient's address:

City: | State: | Zip code:

County: | Phone: | ext.

Race (select all that apply): □ Unknown □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White □ Other race (specify):

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Preferred language: | Patient identifier:

Section 3: Test Information

Instructions: If the test name is not listed, please include brand name, test name, and as much information as possible in the 'Other (specify)' field.

Test name:
- □ Abbott BinaxNOW COVID-19 Ag card
- □ Abbott ID Now COVID-19
- □ Access Bio CareStart COVID-19 Antigen Test
- □ BD Veritor System for Rapid Detection of SARS-CoV-2
- □ Celltrion DiaTrust COVID-19 Ag Rapid Test
- □ Cepheid Xpert Xpress SARS-CoV-2
- □ Cepheid Xpert Xpress SARS-CoV-2/Flu/RSV
- □ GenBody COVID-19 Ag
- □ Indicaid COVID-19 Rapid Antigen Test
- □ LumiraDx SARS-CoV-2 Ag Test
- □ Quidel QuickVue SARS Antigen
- □ Quidel Sofia SARS Antigen FIA
- □ Quidel Sofia 2 Flu + SARS Antigen FIA
- □ Roche cobas SARS-CoV-2 & Influ. A/B Nucleic Acid Test for use on the cobas Liat System
- □ Sienna-Clarity COVID-19 Antigen Rapid Test Cassette
- □ Other (specify):

Test result:
□ Positive/Detected
□ Negative/Not detected
□ Inconclusive/Uncertain

Specimen type:
□ Nasal swab □ Saliva
□ NP (nasopharyngeal swab) □ Throat Swab
□ Other (specify):

Specimen collection date (MM/DD/YYYY): / /

Device identifier: | Specimen ID:

Washington State Department of Health

POC Report Form Field Descriptions

A description for each field in the Report Form is provided below. These explanations are meant to help you fill out the form completely. Please read them before contacting doh-surv@doh.wa.gov with questions on how to fill out the Report Form.

Submitter name	The name of the person filling out the form.
Date submitted	The date this form was sent to the Washington State Department of Health.
Section 1: Testing Facility and Ordering Provider Information	
Facility name	The facility's name.
Ordering provider name	For health care providers or facilities, the full name of the medical provider who ordered the POC test. Other facilities can put "N/A".
NPI (National Provider Identifier)	The provider's or health care facility's NPI. If not available, put "N/A".
CLIA number	The facility's CLIA number.
Ordering facility or provider's address (includes city, state, and zip code)	The ordering facility or provider's physical address.
County	The county where the facility is located.
Phone	The facility's phone number that DOH can call if there are questions.
Section 2: Patient Information	
Last name/First name/Middle initial	Provide the full name of the patient.
Sex at birth	Check the option that best describes the patient.
Date of birth	The patient's date of birth.
Age	The patient's age in years at time of testing. If the patient is a child under 1 year of age, enter 0.
Patient's address (includes city, state, and zip code)	The patient's physical address.
County	The county where the patient lives.
Phone	The best phone number to reach the patient.
Race	Check the option(s) with which the patient identifies.
Ethnicity	Check only one. Check the option with which the patient identifies.
Preferred language	The patient's preferred language.
Patient identifier	Provide the identifier of the patient, if available. Otherwise, put "N/A".
Section 3: Test Information	
Test name	Check only one. Indicate the brand and name of the test the facility used to test this patient.
Test result	Check only one. Indicate the option that identifies the patient's test result.
Specimen type	Check only one. Indicate the type of specimen used for this test. A nasal swab specimen is from just inside of the nostrils whereas a NP (nasopharyngeal swab) specimen is from "deep" in the nose. A saliva specimen is from saliva. A throat swab specimen is from the throat and tonsils. If the specimen type isn't listed, check "Other" and provide details.
Specimen collection date	The date the patient's specimen was collected and tested.
Device identifier (DI)	The DI for some tests can be found in the National Institute of Health's *Access GUDID Database*. The Device Model or full human readable form of the barcode is also acceptable here. If the DI is unknown, put "Unknown."
Specimen ID	If the facility uses or assigns unique identifiers to specimens, provide that ID. If your facility does not, put "N/A".

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Washington State Department of Health