Reset Form

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. Specific instructions are provided on Page 2, and a description for each field in the Report Form is provided on Page 3.

Submitter name: | Date submitted (mm/dd/yyyy):

Section 1: Testing Facility and Ordering Provider Information

Facility name:

Ordering provider name (first and last):

Ordering facility or provider address:

City: | State: | Zip Code:

County: | Phone: ( ) -

Section 2: Patient Information

Last name: | First name: | Middle Initial:

Sex at birth: ☐ Female ☐ Male ☐ Neither/Other ☐ Unknown | Date of birth (mm/dd/yyyy):

Patient's address:

City: | State: | Zip Code:

County: | Phone: ( ) -

Race(s)- (See page 2 for specific instructions):

Ethnicity: ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Unknown ☐ Patient declined to respond

Preferred language (See page 2 for specific instructions):

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
- ☐ Other
- ☐ 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

Test Result:

- ☐ Positive/Detected
- ☐ Negative/Not Detected
- ☐ Inconclusive/Uncertain

Specimen Type:

- ☐ Nasal Swab
- ☐ NP (nasopharengeal swab)
- ☐ Saliva Throat Swab
- ☐ Other (specify):

Specimen collection date (mm/dd/yyyy):

Device identifier: | Specimen ID:

Washington State Department of HEALTH

POC Report Form Field Descriptions

Specific instructions for Section 2: Patient Information - Race(s) and Preferred Language are provided below. A description for each field in the Report Form is provided on Page 3. These explanations are meant to help you fill out the form completely. Please read them before contacting CDSDataSupport@doh.wa.gov with questions on how to fill out the Report Form.

Instructions for Section 2: Patient Information – Race(s)

Enter all the numerical values of the corresponding race(s) that the patient identifies with. Can be multiple values. Please write clearly and put only one number in each box. Please separate the race values using a space in between each race.

1. Afghan	19. Egyptian	37. Kuwaiti	55. Russian
2. Afro-Caribbean	20. Eritrean	38. Lao	56. Samoan
3. Alaska Native	21. Ethiopian	39. Lebanese	57. Saudi Arabian
4. American Indian	22. Fijian	40. Malaysian	58. Somali
5. Arab	23. Filipino	41. Marshallese	59. South African
6. Asian	24. First Nations	42. Mestizo	60. South American
7. Asian Indian	25. Guamanian or Chamorro	43. Mexican/Mexican American	61. Syrian
8. Bamar/Burman/Burmese	26. Hmong/Mong	44. Middle Eastern	62. Taiwanese
9. Bangladeshi	27. Indigenous-Latino/a or Indigenous-Latinx	45. Mien	63. Thai
10. Bhutanese	28. Indonesian	46. Moroccan	64. Tongan
11. Black or African American	29. Iranian	47. Native Hawaiian	65. Ugandan
12. Central American	30. Iraqi	48. Nepalese	66. Ukrainian
13. Cham	31. Japanese	49. North African	67. Vietnamese
14. Chicano/a or Chicanx	32. Jordanian	50. Oromo	68. White
15. Chinese	33. Karen	51. Pacific Islander	69. Yemeni
16. Congolese	34. Kenyan	52. Pakistani	70. Other Race
17. Cuban	35. Khmer/Cambodian	53. Puerto Rican	71. Patient Declined to Respond
18. Dominican	36. Korean	54. Romanian/Rumanian	72. Unknown

Instructions for Section 2: Patient Information – Preferred Language

Enter ONE numerical value corresponding to the preferred language of the patient.

1. Amharic	14. French	27. Mixteco	40. Tagalog
2. Arabic	15. German	28. Nepali	41. Tamil
3. Balochi/Baluchi	16. Hindi	29. Oromo	42. Telugu
4. Burmese	17. Hmong	30. Panjabi/Punjabi	43. Thai
5. Cantonese	18. Japanese	31. Pashto	44. Tigrinya
6. Chinese (unspecified)	19. Karen	32. Portuguese	45. Ukrainian
7. Chamorro	20. Khmer/Cambodian	33. Romanian/Rumanian	46. Urdu
8. Chuukese	21. Kinyarwanda	34. Russian	47. Vietnamese
9. Dari	22. Korean	35. Samoan	48. Other language
10. English	23. Kosraean	36. Sign Languages	49. Patient declined to respond
11. Farsi/Persian	24. Lao	37. Somali	50. Unknown
12. Fijian	25. Mandarin	38. Spanish/Castilian	
13. Filipino/Pilipino	26. Marshallese	39. Swahili/Kiswahili	

POC Report Form Field Descriptions (continued)

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".
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.
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(s)	Please refer to instructions above: **Instructions for Section 2: Patient Information – Race(s)**
Ethnicity	Check only one. Check the option with which the patient identifies.
Preferred language	Please refer to instructions above: **Instructions for Section 2: Patient Information – Preferred Language**.
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 doh.information@doh.wa.gov.