Pearl Medical Laboratory
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PEARL DIAGNOSTIC LABORATORY

Patient Information

Patient Name (Last): (First): (M.I):	Birth Date:	Social Security Number:
Patient Address (Street): (City): (State): (ZIP):	County:	Patient Phone Number:
Contact Email Address:		Patient Sex: (Please circle one) Male ◯ or Female ◯
Patient Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Asian ☐ White		Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Patient type: ☐ Household member Name of person at school: ☐ Staff ☐ Student		School:

Questions for Entry

Is this your first Test? ◯ Y ◯ N ◯ Unknown	Symptomatic as defined by CDC? ◯ Y ◯ N ◯ Unknown If yes, date of onset:_____
Employed in healthcare ◯ Y ◯ N ◯ Unknown	Pregnant? ◯ Y ◯ N ◯ Unknown
Was patient hospitalized due to condition? ◯ Y ◯ N ◯ Unknown	Was patient admitted to ICU for condition of interest? ◯ Y ◯ N ◯ Unknown

Resident in a congregate care setting (including nursing homes, residential care, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care, or other setting ◯ Y ◯ N ◯ Unknown

Consent to be tested for COVID-19:

I have turned in my consent form.

To be completed by person performing specimen collection:

Laboratory Testing: ☐ SARS-CoV-2 (COVID-19) NAA (RT-PCR) Diagnosis Code: ☐ Z20.828

☐ SARS-CoV-2 Rapid Antigen Test

Collection Location: ☐ Saliva ☐ Oral ☐ Nasal

Collection Date: Collection Time: Collector Initials:

Signature of Provider, Collector or Health Official: _____ Date: _____