

MORSE Surveillance Specimen Submission Form

* Required Fields

Submitter

*Submitting Facility:
 (Results sent here) _____

*Address: _____

City: _____ State: _____ Zip: _____

Name of Person Filling Out Form: _____

Phone # for questions/alert values: _____

Ordering Provider: _____

Project Number: 1399

Patient

*Last Name: _____

*First Name: _____ MI: _____

Patient Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Patient MRN #: _____

*DOB (mm/dd/yyyy): _____

Sex: _____ Race: _____

Male	American Indian/Alaska Native
Female	Asian
Other or Unknown	Black
Ethnicity:	Native Hawaiian/Pacific Islander
Hispanic/Latino	White
Non-Hispanic/Latino	Other not listed
Not Provided	Unknown/Not Provided

Specimen

Sample ID: _____

*Date of Collection (mm/dd/yyyy): _____

Time of Collection (##:##): _____ AM PM

* Transport Media: _____ * Storage Condition Prior to Transport: _____

VTM/UTM	Refrigerated
Saline	Frozen

*Source: Nasal Swab
 Nasopharyngeal Swab (NP Swab)
 Oropharyngeal Swab (OP Swab, Throat Swab)
 Other, specify: _____

Collection Facility Information

*Collection Facility Name: _____

Collection Facility is the same as Submitting Facility.
 Skip to section - Facility Type

Address: _____

City: _____ State: _____ Zip: _____

Patient Epidemiological Information

*Does patient have symptoms? If yes, check all that apply:

Fever	Malaise
Cough	Anorexia
Sore Throat	Loss of taste
Rhinorrhea/runny nose	Loss of smell
Coryza/stuffy nose	Conjunctivitis
Wheeze	Earache
Shortness of breath	Vomiting
Apnea	Diarrhea
Chills	Other symptoms (specify):
Muscle aches/pains (myalgias)	
Headache	

Onset Date (mm/dd/yyyy): _____

Test Information and Comments

Test Requested: Influenza SARS-CoV-2 Multiplex PCR (FluSC2PCR)

Submitting Laboratory - Specify Any Other Information or Comments:

Test and Epidemiology Information