GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
761 South Marine Corps Drive, Tamuning, Guam 96913
Telephone: (671) 988-4788/735-7136

GPHL LABORATORY NUMBER

DATE RECEIVED

(PLEASE PRINT LEGIBLY)

ORDERING/PRIMARY PHYSICIAN:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

SUBMITTING LABORATORY:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

CLINICAL DIAGNOSIS

CATEGORY OF AGENT SUSPECTED

I. PATIENT IDENTIFICATION

LAST NAME | FIRST NAME AND MIDDLE INITIAL

RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)
Street:
City: Zip Code:

PHONE NO.:
Cell/Mobile: Home: Work:

OCCUPATION | ETHNICITY (e.g. Chamorro, Filipino, etc.) | DATE OF BIRTH | SEX

DATE OF ONSET

LABORATORY EXAMINATION REQUESTED
COVID-19/SARS-COV-2 PCR

SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN
☑ HUMAN
☐ OTHER (Specify):

2. ORIGINAL MATERIAL

TYPE OF SPECIMEN (SPECIFY SITE OF COLLECTION):
NASOPHARYNGEAL

DATE AND TIME OF COLLECTION:

TRANSPORT MEDIUM:
VIRAL TRANSPORT MEDIA

COLLECTED BY (PRINT NAME):

3. SEROLOGY OF SPECIMEN

COLLECTION DATE:
☐ ACUTE (S1):
☐ CONVALESCENT (S2):
☐ S3:
☐ S4:
☐ OTHER (Specify):

4. SEROLOGY OF SPECIMEN
☐ PURE ISOLATE
☐ MIXED CULTURE
☐ OTHER (Specify):

DATE OF ORIGINAL CULTURE:
PRIMARY ISOLATON MEDIA:
COLLECTON SITE OF ORIGINAL SPECIMEN:

DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED:

SUSPECTED IDENTIFICATION:

OTHER ORGANISMS FOUND:

OTHER INFORMATION:

III. CLINICAL HISTORY

1. CLINICAL SIGNS AND SYMPTOMS
☐ FEVER
☐ EXANTHEMA (Specify Type):
☐ RESPIRATORY SIGNS:
☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT:
☐ GASTROINTESTINAL INVOLVEMENT:

2. ADDITIONAL INFORMATION
TRAVEL HISTORY:

IMMUNIZATIONS:

ANTIBIOTIC THERAPY:

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

DATE OF REPORT:

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

The instrumentation used to conduct the test has significant sensitivity. Nevertheless few negative results should be treated with caution. Patient follow up and repeat testing, if clinically indicated, are recommended.

Patient Last Name: ____________________________ Patient First Name: ________________________
Date of Birth: ___________________

COVID-19 Form for Mass Screening

Date of onset: ________________ (*if symptomatic*)

During this illness, did the patient experience any of the following symptoms?

SYMPTOMS	YES	NO
Fever >100.4F (38C)		
Subjective fever (felt feverish		
Chills		
Muscle aches (myalgias)		
Runny nose		
Sore throat		
Cough (new or worsening)		
Shortness of breath		
Nausea or vomiting		
Headache		
Abdominal pain		
Diarrhea		
Loss of sense of smell or taste or appetite		
Congestion		
Fatigue/weakness		
Rash		
Other (specify):		

Does the patient have any pre-existing medical conditions?

CONDITION	YES	NO
Chronic lung disease (asthma, emphysema, COPD)		
Diabetes mellitus		
Cardiovascular disease		
Hypertension only (high blood pressure)		
Chronic renal disease (ESRD/CRI)		
Chronic liver disease		
Immunocompromised condition (cancer, chemo, lupus, HIV etc).		
Neurological/neurodevelopmental/intellectual disability		
Hepatitis		
Other (specify):		
Former smoker		
Current smoker		

Contact with another lab-confirmed COVID-19 patient? Yes ____No____
Previous COVID-19 testing? Yes ____No____ If *"Yes"*, Date of collection:___________________

Name of Interviewer: Last ______________________________ First ______________________________

Date of Interview: _______________________