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

(PLEASE PRINT LEGIBLY)

☐ Walk-in #_____

☐ Drive-Thru #_____

GPHL LABORATORY NUMBER

DATE RECEIVED

ORDERING/PRIMARY PHYSICIAN:

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

SUBMITTING LABORATORY:

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

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/EMPLOYER	ETHNICITY (e.g. Chamorro, Filipino, etc.)	DATE OF BIRTH	SEX

CLINICAL DIAGNOSIS

DATE OF ONSET

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

CATEGORY OF AGENT SUSPECTED

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:
SWABBED BY RN / LPN (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: ☐ YES ☐ NO
SPECIFY:
IMMUNIZATIONS:
ANTIBIOTIC THERAPY:

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

DATE OF REPORT:_____

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: _____

Guam Public Health Laboratory COVID-19 Form

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		
Loss of sense of taste or smell		
Headache		
Fatigue/weakness		
Cough (new onset)		
Shortness of breath		
Difficulty breathing		
Chest pain		
Nausea or vomiting		
Abdominal pain		
Diarrhea		
Other (specify):		

Does the patient have any pre-existing medical conditions?

CONDITION	YES	NO
Diabetes mellitus		
Hypertension only (high blood pressure)		
Severe obesity		
Cardiovascular disease		
Chronic renal disease (ESRD/CRI)		
Chronic liver disease		
Chronic lung disease (asthma/emphysema/COPD)		
Immunocompromised condition (cancer, chemo, lupus, HIV etc)		
Current smoker		
Former smoker		
Is the patient currently pregnant?		
Other (specify):		

Contact with another lab-confirmed COVID-19 patient? Yes ____No____ Index:_____

Type of Contact: ☐ **Household** ☐ **Community** ☐ **Workplace** ☐ **Healthcare**

Has the patient ever tested positive for COVID-19? Yes ____No____ Date of result:_____

Name of Interviewer: Last _____ **First** _____

Investigator: _____ **Date of Interview:** _____