



# This is an official Oklahoma Health Alert

## Network Health Advisory

The Oklahoma State Department of Health (OSDH) Acute Disease Service (ADS) is now using 4 types of documents to provide important information to medical and public health professionals, and to other interested persons:

### Categories of Health Alert messages:

#### Health Alert

Provides vital, time-sensitive information for a specific incident or situation; warrants immediate action or attention by health officials, laboratorians, clinicians, and members of the public and conveys the highest level of importance.

#### Health Advisory

Provides important information for a specific incident or situation; contains recommendations or actionable items to be performed by public health officials, laboratorians, and/or clinicians; may not require immediate action.

#### Health Update

Provides updated information regarding an incident or situation; unlikely to require immediate attention.

#### Health Info/Event

Provides general public health information; unlikely to require immediate action.

March 24, 2020

OKHAN\_307--2020\_03-24 ADV-N

Reference: N/A

### Process to Order a COVID-19 Test

Physicians can order a COVID-19 test (for patients meeting the testing criteria noted) by following the below procedure for submission to the OSDH PHL:

**EFFECTIVE 3/27/2020, Specimens submitted**

**without PUI, Screening Template, and Lab**

**Requisition Forms will be UNSAT for testing.**

1. Complete the OSDH PHL Test Requisition Form (ODH 419).
  - a. Accessible in PHOCIS and PHIDDO. Also, a hardcopy or fillable copy is available at <http://phl.health.ok.gov> (Forms).
  - b. Information on the form must match identifiers used to label the specimen.
2. Review the Guidelines for Shipping Clinical Specimens Classified as a Biological Substance. Double-bag specimens or place in Category B box, as available.
3. Submit specimen as follows:
  - a. Hospitals and county health departments with routine OSDH PHL contracted courier service: Submit specimens using the regular courier service currently provided to your facility.
  - b. Other sites: Submit specimens to your local county health department.
    - Please, contact the county health department ahead of time to make sure the facility is open.
    - Submit ONE swab in viral transport medium (VTM), universal transport medium (UTM), M4 or equivalent.

**Note:** While the FDA has indicated that liquid Amies-based transport media (e.g., Copan E-Swab or Puritan Opti-Swab systems) or a dry swab in sterile saline could be used to collect and transport samples for COVID-19 testing, neither the CDC or the OSDH PHL have verified the performance characteristics of these collection devices. **Therefore, until further guidance from the CDC is provided, the OSDH PHL cannot accept these specimens for use in the CDC test.**

### Summary Points

- National shortage of nylon nasopharyngeal swabs
- PUI Form
- Process to order COVID-19 Test
- Testing Criteria at PHL
- PHL Requisition Form
- Script for Provider Evaluation

Message #: OK-HAN\_307 / Reference: N/A

Oklahoma State Department of Health / Acute Disease Service / 1000 NE 10<sup>th</sup> St, Oklahoma City, OK 73117  
405-271-4060 (ph) / 405-271-6680 (fax) <http://ads.health.ok.gov>



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### Hardcopy Requisition

- In the lower right-hand corner of the form, checkmark the "Other" box and hand-write "**Coronavirus**" or "**COVID-19**" or "**SARS-CoV-2**" or "**2019 nCoV**" in the blank space.
- Checkmark the "Nasopharynx" box in the Specimen Information section of the form.

Coronavirus is not currently listed on the hardcopy PHL test requisition. What test should be ordered?

### Fillable Requisition

- This form has been updated to include a Coronavirus-2019 selection.

### Additional Forms

Complete and submit the submit the Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form and the Screening Template for COVID-19 Testing at the OSDH Public Health Laboratory (see attached) to ensure the testing criteria are met.

**Due to the widescale shortages of laboratory supplies and reagents, hospitals should use private laboratories for COVID-19 testing.**

### **COVID-19 Testing Criteria at the OSDH PHL**

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. **Only submit specimens for patients who present with**

Fever (at least 100.4°F) **AND** symptoms of acute respiratory illness (e.g., cough, difficulty breathing),

**AND** one of the following:

- Hospitalized patients who have signs and symptoms compatible with COVID-19 and other respiratory illnesses have been ruled-out in order to inform decisions related to infection control.
- Other symptomatic individuals at higher risk for poor outcomes, including those who are ≥ 65 years, immunocompromised or have chronic medical conditions (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).

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- Suspected outbreak of COVID-19 among associated individuals with recent onset of similar fever and lower respiratory symptoms. Please, contact the OSDH Acute Disease Service at (405) 271-4060 to report suspected outbreaks.
- Suspect COVID-19 in a patient associated with a high-risk exposure setting such as a long-term care facility.
- Patients, including healthcare personnel, who within 14 days of symptom onset had close contact with a suspect or laboratory-confirmed COVID-19 patient.

### Additional Laboratories Conducting COVID-19 Testing (Listing of laboratories is not exhaustive nor an indication of endorsement):

Clinical Pathology Laboratories: <https://www.cpillabs.com/clinicians/coronavirus-disease-covid-19/>

DLO/Quest Diagnostics: <https://www.dlolab.com/covid-19>

LabCorp: <https://www.labcorp.com/information-labcorp-about-coronavirus-disease-2019-covid-19>

Mayo Clinic: <https://www.mayocliniclabs.com/test-catalog/Overview/75578>

Regional Medical Laboratory: <http://www.rmlonline.com/site/sections/705>

If healthcare provider staff do not currently receive the Oklahoma Health Alert Network (OK-HAN) notifications, please advise personnel to contact [OKHAN@health.ok.gov](mailto:OKHAN@health.ok.gov) for access or by calling the ADS and asking for the OK-HAN Coordinator.

### References

- Oklahoma Acute Disease COVID-19 web page: <https://coronavirus.health.ok.gov/>
- <https://www.cdc.gov/coronavirus/2019-ncov/index.html>

**## This message has been distributed to Primary Care and Infectious Disease Physicians, Infection Preventionists, Laboratorians, Urgent Care Centers, Emergency Departments, and State and Local Health Officials ##**

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Oklahoma State Department of Health / Acute Disease Service / 1000 NE 10<sup>th</sup> St, Oklahoma City, OK 73117  
405-271-4060 (ph) / 405-271-6680 (fax) <http://ads.health.ok.gov>

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Physical Address: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_



.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

## Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: \_\_\_\_\_

Case state/local ID: \_\_\_\_\_

Reporting health department: \_\_\_\_\_

CDC 2019-nCoV ID: \_\_\_\_\_

Contact ID <sup>a</sup>: \_\_\_\_\_NNDSS loc. rec. ID/Case ID <sup>b</sup>: \_\_\_\_\_

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. <sup>b</sup>For NNDSS reporters, use GenV2 or NETSS patient identifier.

### Interviewer information

Name of interviewer: Last \_\_\_\_\_ First \_\_\_\_\_

Affiliation/Organization: \_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_

### Basic information

What is the current status of this person? <input type="checkbox"/> PUI, testing pending* <input type="checkbox"/> PUI, tested negative* <input type="checkbox"/> Laboratory-confirmed case * Testing performed by state, local, or CDC lab.		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other		Date of first positive specimen collection (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 ____/____/____ (MM/DD/YYYY) If yes, discharge date 1 ____/____/____ (MM/DD/YYYY) Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____ Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date of death	
Report date of PUI to CDC (MM/DD/YYYY): ____/____/____ Report date of case to CDC (MM/DD/YYYY): ____/____/____ County of residence: _____ State of residence: _____		Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units(yr/mo/day): _____			
Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown		If symptomatic, onset date (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown		If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date			
Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Travel to a geographically affected area per CDC; <a href="https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html">https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html</a> Specify site(s): _____ <input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW <input type="checkbox"/> Animal exposure <input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown If the patient had contact with another COVID-19 case, was this person a U.S. case? Yes / No <input type="checkbox"/> Yes, nCoV ID of source case: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A							
Under what process was the PUI or case first identified? (check all that apply): <input type="checkbox"/> Clinical evaluation leading to PUI determination <input type="checkbox"/> Contact tracing of case patient <input type="checkbox"/> Routine surveillance <input type="checkbox"/> EpiX notification of travelers; if checked, DGMQID _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____							

CDC 2019-nCoV ID: 

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

## Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

### Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C) <sup>c</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other, specify: _____	

Pre-existing medical conditions?

☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chronic Renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chronic Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Immunocompromised Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental/intellectual disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(If YES, specify) _____
Other chronic diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(If YES, specify) _____
If female, currently pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Current smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

#### Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
OP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
Sputum			<input type="checkbox"/>		<input type="checkbox"/>	
Other:			<input type="checkbox"/>		<input type="checkbox"/>	

**SPECIFY LOCATION FOR SPECIMEN PICK UP:**  
\_\_\_\_\_

Additional State/local Specimen IDs: \_\_\_\_\_

**Oklahoma State Department of Health  
Public Health Laboratory  
Healthcare Provider Guidance for Evaluation and Testing for COVID-19  
March 24, 2020**

**Specimen Submission Criteria**

There is a national shortage of COVID-19 test kits and reagents. To make the best use of laboratory testing resources, please only submit specimens to the OSDH PHL that are compatible with the criteria indicated in this OK-HAN. The OSDH PHL will not test specimens for patients who do not meet these criteria; these specimens will be unsat for testing.

Clinicians should submit specimens for patients who do not meet the criteria to a commercial laboratory that provides SARS-CoV-2 testing (e.g., LabCorp, Quest, Clinical Pathology Laboratories or any reference laboratory your facility uses). Please, contact these commercial laboratories to find out the correct process for submission of specimens for testing.

**Collection of Swab Specimens**

Refer to *Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease (COVID-2019)* <https://www.cdc.gov/coronavirus/2019-nCoV/guidelines-clinical-specimens.html>

- For initial COVID-19 diagnostic testing, CDC currently recommends collection of a single upper respiratory **nasopharyngeal (NP) swab** only.

**Note:** *Collection of oropharyngeal swabs (OP) is a lower priority and if collected should be combined in the same tube as the NP. Collection of only OP swab is acceptable if other swabs are not available.*

*To conserve testing supplies and reagents, please **use only a single swab per patient**.*

- Submit ONE swab in viral transport medium (VTM), universal transport medium (UTM), M4 or equivalent.

**Note:** *While the FDA has indicated that liquid Amies-based transport media (e.g., Copan E-Swab or Puritan Opti-Swab systems) or a dry swab in sterile saline could be used to collect and transport samples for COVID-19 testing, neither the CDC or the OSDH PHL have verified the performance characteristics of these collection devices. Therefore, until further guidance from the CDC is provided, the OSDH PHL cannot accept these specimens for use in the CDC test.*

*NP swab collection kits may be available at your local county health department. Please, call ahead to make sure they have supplies. Currently, these kits are available in limited numbers and must only be used for COVID-19 testing at the OSDH PHL.*

- Specimens should be collected using only swabs with a synthetic fiber tip (e.g., nylon, Rayon, Dacron), and a plastic or aluminum shaft. Calcium alginate swabs are unacceptable and cotton swabs with wooden shafts are not recommended.
- **Collection:** Follow specimen collection device manufacturer instructions for proper collection or use the steps indicated below.



- a. Label a sterile transport tube containing 2-3 mL of VTM, UTM, M4 or equivalent with the patient's name, one other patient-specific identifier and the date of collection.
  - b. If the nasal passages have a large amount of mucus, ask the patient to blow their nose before collecting the specimen.
  - c. With the thumb of one hand, gently elevate the tip of the patient's nose, and then gently insert the NP swab into the nostril.
  - d. Guide the swab backward and upward along the nasal septum until a distinct resistance is met, hold it there for a few seconds then with a rotating motion, gently remove it.
  - e. Immediately, place swab in the labeled viral transport tube.
  - f. Break-off or cut excess shaft of the swab so that the tube can be capped; swab must be present in transport medium to be acceptable for testing.
  - g. Secure the cap of the tube with Parafilm to prevent leakage during transport.
- **Storage:** Store specimens at 2-8°C for up to 72 hours after collection. If a delay in testing or shipping is expected, store specimens at -70°C or below.
  - **Forms:**
    - a. Complete the OSDH PHL *Test Requisition Form* (ODH 419).
      - Accessible in PHOCIS and PHIDDO. Also, a hardcopy is available at [http://phl.health.ok.gov \(Forms\)](http://phl.health.ok.gov (Forms)).
      - Information on the form must match identifiers used to label the specimen.
    - b. Complete a *Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form* to ensure the testing criteria are met.
  - **Submission to the OSDH PHL:**
    1. Review the Guidelines for Shipping Clinical Specimens Classified as a Biological Substance. Double-bag specimens or place in Category B box, as available.
    2. Submit specimen together with requisition form and PUI form as follows:
      - a. **Hospitals and county health departments with routine OSDH PHL-contracted courier service:** Submit using the regular courier service currently provided to your facility.
      - b. **Other sites:** Submit to your local county health department. Please, contact the county health department ahead of time to make sure the facility is open.

## Reporting

Test results will be issued to the submitter via US Mail, fax (if the submitter has not received test results from the OSDH PHL before, they will need to complete and submit a *Fax Verification Form* at the time of submission – see attached), or PHOCIS (for county health department submissions only).

If clinicians have questions regarding these priority criteria, please call the OSDH Acute Disease Service at (405) 271-4060.



Oklahoma State Department of Health  
Creating a State of Health

## Oklahoma State Department of Health Public Health Laboratory

1000 N.E. 10<sup>th</sup> Street, Oklahoma City, OK 73117-1299  
Tel: (405)271-5070; Fax: (405)271-4850  
Email: [PublicHealthLab@health.ok.gov](mailto:PublicHealthLab@health.ok.gov)  
Test Directory: <http://phl.health.ok.gov>

Laboratory Director:  
S. Terence Dunn, PhD  
CLIA #: 37D0656594

Please, PRINT; \*indicates required fields

### Patient Information

Name\* (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ DOB\* \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_

Sex:\* ☐ M ☐ F

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/ Alaska Native

(mark all applicable) ☐ Native Hawaiian/Other Pacific Islander ☐ Other

### Submitter Information

Practitioner Name\* (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ NPI \_\_\_\_\_

Facility Name\* \_\_\_\_\_ Phone # ( ) - Fax # ( ) -

Address\* \_\_\_\_\_ City\* \_\_\_\_\_ State \_\_\_\_ Zip\* \_\_\_\_\_

### Clinical Information

Diagnosis \_\_\_\_\_ Onset (mm-dd-yyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Antibiotics (list and start dates) \_\_\_\_\_

### Specimen Information

Collection Date (mm-dd-yyy)\* \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time (hour:minute) \_\_\_\_\_ AM / PM By \_\_\_\_\_

Source/Type\* (check one only)

- |  |   |  |   |  |  |  |  |
|--|---|--|---|--|--|--|--|
| <input type="checkbox"/> Blood                                     | <input type="checkbox"/> Serum                    | <input type="checkbox"/> Urine           | <input type="checkbox"/> Stool          | <input type="checkbox"/> CSF                     | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Pericardial fluid | <input type="checkbox"/> Blood smears      |
| <input type="checkbox"/> Sputum, expect.                           | <input type="checkbox"/> Sputum, induced          | <input type="checkbox"/> Bronchial brush | <input type="checkbox"/> Bronchial wash | <input type="checkbox"/> Bronchoalveolar lavage  | <input type="checkbox"/> Rectum/anus   | <input type="checkbox"/> Vagina            | <input type="checkbox"/> Tracheal aspirate |
| <input checked="" type="checkbox"/> Nasopharynx                    | <input type="checkbox"/> Oropharynx               | <input type="checkbox"/> Nasal wash      | <input type="checkbox"/> Eye            | <input type="checkbox"/> Wound/Lesion (specify): | <input type="checkbox"/> Cervix        |  |  |
| <input type="checkbox"/> Tissue (specify):                         |   |  |   |  |  |  |  |
| <input type="checkbox"/> Cultured isolate (specify suspect agent): | <input type="checkbox"/> Environmental (specify): |  |   |  |  |  |  |
| <input type="checkbox"/> Other (specify):                          |   |  |   |  |  |  |  |

### Test Request (mark one only)

#### Bacteriology

- ☐ Bacterial isolate, identification/serotyping/confirmation  
Variable specimen according to source (contact lab)
- ☐ Bacteria, non-enteric, isolation and identification  
Variable specimen according to source (contact lab; requires pre-approval)
- ☐ Enteric pathogens, isolation and identification  
Feces, 2 g or 5-10 mL in Cary Blair or GN Broth (STEC only)
- ☐ Bordetella  
Nasopharynx, 1 or 2 swabs; Isolate, confirm visible growth
- ☐ Chlamydia/Gonorrhea  
Urine, first 20-60 mL of void – transfer to UPT tube; Vaginal swab, use only BD vaginal specimen transport device
- ☐ Group B streptococcus  
Vaginal/anal swab in LIM broth (combined vaginal/anal collection preferred)
- ☐ Syphilis, serology (reverse algorithm)  
Serum in SST, 2 mL
- ☐ Bacteria, environmental (contact lab)

#### Mycobacteriology/Mycology

- ☐ Fungal isolate, identification  
Plate or slant with visible growth
- ☐ Mycobacteria, smear and culture w/ reflex to identification  
Respiratory sediments, 5-10 mL; Sterile fluid, >2 mL; Blood, 5-10 mL ACD or heparin; Tissue, 1 g; Urine, >5 mL
- ☐ Mycobacteria, isolate identification  
Liquid culture, >3 mL; Solid culture, visible growth
- ☐ *M. tuberculosis* complex PCR  
Respiratory sediments, 5-10 mL (CHDs require OSDH TB physician pre-approval)

#### Virology

- ☐ Hepatitis B surface antigen (HBsAg)  
Serum, 2 mL (approved submitters only)
- ☐ HIV-1/2 antigen/antibodies  
Serum in SST, 2 mL (approved submitters only)
- ☐ Human papillomavirus, high risk  
Residual ThinPrep, 1 mL
- ☐ Influenza virus A and B  
Nasopharyngeal (preferred), nasal or throat swabs, 1 or 2 in VTM
- ☐ Respiratory Pathogen Panel  
Nasopharyngeal swab, 1 or 2 in VTM, or equivalent media
- ☐ Rubella antibodies  
Serum in SST, 1 mL (female CHD patients only)
- ☐ West Nile virus/St. Louis encephalitis virus, IgM antibodies  
Serum in SST, 2 mL; CSF, 1 mL (CSF must be accompanied by serum)
- ☐ Zika virus, chikungunya virus, dengue virus, PCR  
Serum in SST, 2 mL; CSF, 1 mL; Urine 1 mL; Amniotic fluid 1 mL (CSF, urine and amniotic fluid must be accompanied by serum) (contact lab; requires pre-approval)

#### Parasitology

- ☐ Parasites, blood  
Babesia/trypanosomes/filariiae: Giemsa or Giemsa-Wright-stained blood smears, 1 thick and 1 thin  
Malaria: Giemsa or Giemsa-Wright-stained blood smears, 1 thick and 1 thin AND 2-6 mL EDTA blood

#### Other

- ☒ Other (write-in description of test)

COVID-19





Oklahoma State Department of Health  
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## Screening Template for COVID-19 Testing at the OSDH Public Health Laboratory

### Symptoms

- Does the patient have a fever above 100.4°F and symptoms of acute respiratory illness? (e.g., cough, difficulty breathing)

☐ Yes

☐ No

**AND**

### Risk Factors

- ☐ Hospitalized patients who have signs and symptoms compatible with COVID-19 and other respiratory illnesses have been ruled-out in order to inform decisions related to infection control.
  - ☐ Other symptomatic individuals at higher risk for poor outcomes, including those who are ≥ 65 years, immunocompromised or have chronic medical conditions (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
  - ☐ Suspected outbreak of COVID-19 among associated individuals with recent onset of similar fever and lower respiratory symptoms. Please, contact the OSDH Acute Disease Service at (405) 271-4060 to report suspected outbreaks.
  - ☐ Suspect COVID-19 in a patient associated with a high-risk exposure setting such as a long-term care facility.
  - ☐ Patients, including healthcare personnel, who within 14 days of symptom onset had close contact with a suspect or laboratory-confirmed COVID-19 patient.
- **Specimens for patients who do not meet the Symptoms criteria AND at least one of the Risk Factors criteria above for testing will not be tested at the OSDH Public Health Laboratory.** Clinicians should seek testing at a reference laboratory for those not meeting the criteria above.
  - Mildly ill (low grade fever, aches and pains, and dry cough) patients should be encouraged to stay home and contact their healthcare provider by phone for guidance about clinical management.

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