WASHINGTON STATE COVID-19 POINT OF CARE TEST RESULT REPORT FORM

Complete one form per result. Submit by fax to the Washington State Department of Health at (206) 512-2126.

Submitter name: | Submitted date (MM/DD/YYYY): ____ / ____ / _____

Section 1: Testing Facility and Ordering Provider Information

Facility name: Kitsap Severe Weather Shelters | License or CLIA number (if applicable): NA

Facility address: | City:

State: WA | Zip code: | County: Kitsap | Phone:

Type of facility:
- □ Airport/Transit station
- □ Assisted Living/Adult Family Home
- □ Childcare or daycare
- □ College/University
- □ Congregate housing (e.g., dorm, military)
- □ Correctional setting
- □ Drive-/walk-through testing site
- □ Hospital
- □ Inpatient behavioral health care
- □ Nursing Home
- □ Outpatient care (including freestanding emergency department, urgent care)
- □ Homeless shelter
- □ Pharmacy
- □ K-12 School
- □ Supported living
- ■ Other (specify): Emergency Shelter

Ordering provider name (first and last): NA | Phone: NA | NPI (if applicable): NA

Ordering provider street address: NA

Ordering provider city: NA | Zip code: NA | County: NA

Section 2: Patient Information

Last name: | First name: | Middle name:

Sex at birth: □ Female □ Male □ Neither/Other □ Unknown

Is the patient: □ Pregnant □ Postpartum □ Unknown □ Neither pregnant nor postpartum

What is the patient's affiliation to the facility? □ Resident □ Staff ■ Visitor □ Patient □ Student □ Client □Inmate

Date of birth (MM/DD/YYYY): _____ / _____ / _____

Age: _____ years | Did the patient die? □ Yes ■ No | Date of death (MM/DD/YYYY): _____ / _____ / _____

Patient's address: | City:

State: | Zip code: | County: | Phone:

Race (select all that apply):
- □ Unknown
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or other Pacific Islander
- □ White
- Other race (specify): _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Did the patient have symptoms at time of testing? □ Yes □ No □ Unknown

Patient identifier (if applicable): _____ ■ N/A
- □ Medical Record Number
- □ Patient Internal ID
- □ Public Health Case ID
- □ Specimen Identifier
- □ Patient External ID
- □ Other (specify): _____

Section 3: Test Information

Test name:
- □ Abbott BinaxNOW COVID-19 Ag Card
- ■ Access Bio CareStart COVID-19 Antigen Test
- □ BioFire Diagnostics Respiratory Panel 2.1-EZ
- □ Cue Health Cue COVID-19 Test
- □ LumiraDx SARS-CoV-2 Ag Test
- □ Quidel Sofia 2 Flu + SARS Antigen FIA
- □ Quidel Sofia SARS Antigen FIA
- □ Abbott ID NOW COVID-19
- □ BD Veritor System for Rapid Detection of SARS-CoV-2
- □ Cepheid Xpert Xpress SARS-CoV-2 test
- □ Luminostics Clip COVID Rapid Antigen Test
- □ Roche cobas SARS-CoV-2 & Influenza A/B Nucleic Acid Test for use on the cobas Liat System
- □ Other (specify): _____

Specimen type:
- ✓ Nasal swab
- NP (nasopharyngeal swab)
- Other (specify): _____

Test result:
- ■ Detected/Positive
- □ Not detected/Negative
- □ Inconclusive/Undetermined/Invalid/Equivocal

Specimen collection date (MM/DD/YYYY): ____ / ____ / _____

Device identifier: | Specimen ID:

Washington State Department of Health

POC Report Form Field Descriptions

A description for each field in the Report Form is provided below. These explanations are intended to help you fill out the form completely. Please read them before contacting doh-surv@doh.wa.gov with questions on how to fill out the Report Form.

WASHINGTON STATE COVID-19 POINT OF CARE TEST RESULT REPORT FORM

Submitter name	The name of the person filling out the form
Submitted date	The date this form was sent to the Washington State Department of Health
Section 1: Testing Facility and Ordering Provider Information	
Facility name	The facility's name
License number or CLIA number (if applicable)	The facility's state license number or CLIA number. If the facility doesn't have either number, put "N/A".
Facility address (including city, state, and zip code)	The facility's physical address. Use only five-digit zip codes.
County	The county where the facility is located
Phone	The facility's phone number that DOH can call if there are questions about results. Use 10-digit phone numbers.
Type of facility	Check only one. Check the best option that describes the facility. If the facility type isn't listed, check "Other" and provide additional details.
Ordering provider name (first and last)	For health care providers or facilities, the full name of the medical provider who ordered the POC test. Other facilities can put "N/A".
Phone	The ordering provider's phone number. Use 10-digit phone numbers. If there is not an ordering provider, put "N/A".
NPI (if applicable)	The order provider's or health care facility's National Provider Identifier (NPI). If there is not an NPI, put "N/A".
Ordering provider street address (includes city and zip code)	The ordering provider's physical address where they work. Use only five-digit zip codes. If there is not an ordering provider, put "N/A".
Section 2: Patient Information	
Last name, First name, and Middle name	Provide the full name of the patient
Sex at birth	Check the option that best describes the patient
Is the patient pregnant?	Check the option that best describes the patient
What is the patient's affiliation to the facility?	How the patient is related to the facility where he or she was tested
Date of birth	The patient's date of birth
Age	The patient's age in years at time of testing. If the patient is a child under 1 year of age, enter 0.
Patient's address (includes city, state, and zip code)	The patient's physical address. Use only five-digit zip codes.
County	The county where the patient lives
Phone	The best phone number to reach the patient. Use 10-digit phone numbers; if area code is unknown, enter 999 (example: (999) 555-1234).
Did the patient die?	Check the option that best describes the patient
Date of death	If the patient died, indicate the date the patient died
Race	Check the option(s) with which the patient identifies
Ethnicity	Check only one. Check the option with which the patient identifies
Did the patient have symptoms at the time of testing?	Indicate if the patient had symptoms of COVID-19 disease. This includes cough, shortness of breath or difficulty breathing, fever, chills, muscle

	pain, sore throat, and new loss of taste or smell. Other less common symptoms include nausea, vomiting, or diarrhea.
Patient identifier	Check only one. If your facility uses or assigns identifiers to patients, check the option used and provider the identifier of the patient. If your facility does not use or assign identifies, check "N/A".
Section 3: Test Information	
Test name	Check only one. Indicate the brand and name of the test the facility used to test this patient.
Specimen type	Check only one. Indicate the type of specimen used for this test. A nasal swab specimen is obtained by inserting an absorbent tip into both nostrils, just around the inside of the nostrils (also referred to as "nares"). A NP (nasopharyngeal swab) specimen is obtained from "deep" in the nose. If the specimen type isn't listed, check "Other" and provide additional details.
Test result	Check only one. Indicate the option that identifies the patient's test result.
Specimen collection date	The date the patient's specimen was collected and tested
Device identifier (DI)	The DI for some tests can be found in the National Institute of Health's *Access GUDID Database*. The Device Model is also acceptable here, or the full human readable form of the barcode. If the DI is unknown, put "Unknown."
Specimen ID	If the facility uses or assigns unique identifiers to specimens, provide that ID. Many facilities using POC testing may not use specimen IDs because specimens are not stored. In that case, put "N/A".