Pearl Medical Laboratory
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PEARL DIAGNOSTIC LABORATORY

Patient Information

Patient Name (Last): (First): (M.I):	Birth Date:	Social Security Number:
Patient Address (Street): (City): (State): (ZIP):	County:	Patient Phone Number:
Contact Email Address:		Patient Sex: (Please circle one) Male or Female
Patient Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Asian ☐ White		Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Patient type: ☐ Household member ☐ Staff ☐ Student Name of person at school:		School:

Questions for Entry

Is this your first Test? Y or N or Unknown	Symptomatic as defined by CDC? Y or N or Unknown If yes, date of onset:________________
Employed in healthcare? Y or N or Unknown	Pregnant? Y or N or Unknown
Was patient hospitalized due to condition? Y or N or Unknown	Was patient admitted to ICU for condition of interest? Y or N or Unknown
Resident in a congregate care setting (including nursing homes, residential care, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care, or other setting)? Y or N or Unknown	

Consent to be tested for COVID-19:

☐ ***I have turned in my consent form.***

To be completed by person performing specimen collection:

Laboratory Testing: ☐ SARS-CoV-2 (COVID-19) NAA (RT-PCR) Diagnosis Code: ☐ Z20.828

☐ SARS-CoV-2 Rapid Antigen Test

Collection Location: ☐ Saliva ☐ Oral ☐ Nasal

Collection Date: Collection Time: Collector Initials:

Signature of Provider, Collector or Health Official: _________________________________ Date: ____________________