Arkansas Department of Health

Public Health Laboratory
201 South Monroe
Little Rock, AR 722065

COVID-19 Test Request Form

ADH HAI

Last Name	First Name	Middle Initial	Sex
			M F

Street Address	Phone Number

City	State	Zip Code	Social Security Number

Email Address	Date of Birth (MM/DD/YY)	Ethnicity
		___Hispanic ___Non-hispanic ___Unknown

Collection Date (MM/DD/YY)	Collection Time	Ethnicity
		___Hispanic ___Non-hispanic ___Unknown

Race:

___White ___Black or African American ___American Indian/Native Alaska ___Asia ___Native Hawaiian/Pacific Islander ___Other

Required Patient or Legal Guardian Information

Last Name	First Name	Date of Birth (MM/DD/YY)	Sex
			M F

Street Address	Phone Number

City	State	Zip Code	Relationship to Patient (e.g. mother, father, legal guardian)

Parent/Legal Guardian verifies that:

☐ I give consent to Baptist Health and its staff for the individual listed on this form to be tested for COVID-19.

Submitter Name	Contact Person	Email address
ASMSA	Monica Jaskovic	jaskovicm@asmsa.org

Street Address	Phone Number
200 Whittington Ave.	501-622-5202

City	State	Zip Code
Hot Springs	AR	71913

Epidemiology Information

Is patient a health care worker?	Is patient pregnant	Is this patient's first COVID-19 test?	Does patient have underlying medical conditions?
___Yes ___No ___Unknown	___Yes ___No	___Yes ___No ___Unknown	___Yes ___No ___Unknown

Is patient a resident in a congregate setting (student housing, dorm, etc.)?	Has patient had contact with a confirmed case of COVID-19?
___Yes ___No ___Unknown	___Yes ___No ___Unknown

Does patient have the following symptoms:

___Fever ___Sore throat ___Chills ___Asia ___Muscle Aches ___Abdominal pain ___Cough ___Shortness of breath
___Vomiting ___Diarrhea ___New loss of taste ___New loss of smell ___None/Asymptomatic
If experiencing symtoms, indicate date of onset? (MM/DD/YY)_____