

- **Ensure all information is completed for all patients.**
- This form must be submitted with the specimen to KHEL
- Beginning 12/21/2020, KHEL will automatically perform testing for Influenza A & B in addition to SARS-CoV-2

KDHE lab use only

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PROVIDER INFORMATION

Facility Name: _____ KHEL Facility ID: _____ Clinician Name: _____

Facility Address: _____ City: _____ State: _____ ZIP: _____

Existing KHEL facilities can contact KHEL Customer Service to change/verify report method (785) 296-1620 | kdhe.khel_help@ks.gov

NEW KHEL FACILITY ONLY — COMPLETE REPORT DELIVERY OPTIONS BELOW

Lab report delivery preference: _____ Fax #: _____ Secure Email: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ Mobile Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

NO PO BOX – PHYSICAL ADDRESS ONLY

County of residence: _____ Parent/Guardian Name: _____

Sex: Male Female Ethnicity: Non-Hispanic Hispanic Unknown

Race: White Black Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander

SPECIMEN INFORMATION

Collection Date: _____ Time: _____ AM/PM Date test ordered: _____

Specimen type: Nasopharyngeal swab Oropharyngeal (throat) swab Mid-turbinate (nasal swab)
Anterior nares (nasal swab) Blood/Serum (KDHE Epidemiology approval needed)

Test ordered: RT-PCR Antigen Serology Collected by: healthcare staff Self-collected

SYMPTOMS AND EXPOSURE INFORMATION

Symptom onset date of first symptom: _____ Asymptomatic (no symptoms)

Fever (subjective/or measured: _____ °F/°C) Cough Shortness of Breath Difficulty breathing

Sore Throat Loss of smell/taste Rigors or chills Myalgia or muscle aches Headache

Malaise or feeling very tired Pneumonia Diarrhea Nausea/vomiting Congestion/runny nose

Acute Respiratory Distress Syndrome

Immunocompromised/Chronic Condition? Yes, specify: _____ No

Exposure? _____