Clear Form

GVB TRAVEL

The Plaza ___ Hyatt ___ Nikko ___ PIC ___

GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
761 South Marine Corps Drive, Tamuning, Guam 96913
Telephone: (671) 300-9085/9096/9097/9098 Fax: (671) 300-9989

(PLEASE TYPE INFORMATION AND OR PRINT LEGIBLY) Email:

GPHL LABORATORY NUMBER

DATE RECEIVED

ORDERING/PRIMARY PHYSICIAN: Dr. Robert Leon Guerrero

ADDRESS: **DPHSS NRCHC**

Street: 520 WEST SANTA MONICA AVENUE
City: DEDEDO State: GUAM
Country: USA Zip Code: 96929
Phone No.: (671) 635-7492

SUBMITTING LABORATORY:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

I. PATIENT IDENTIFICATION

LAST NAME | FIRST NAME AND MIDDLE INITIAL

RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)

Street:

City: Zip Code:

PHONE NO.:
Cell/Mobile: Home: Email:

EMPLOYER & OCCUPATION | ETHNICITY (e.g. Chamorro, Filipino, Chuukese) | DATE OF BIRTH | SEX

CLINICAL DIAGNOSIS | DATE OF ONSET | LABORATORY EXAMINATION REQUESTED
COVID-19/SARS-COV-2-PCR

CATEGORY OF AGENT SUSPECTED | SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN
   - ☑ HUMAN
   - ☐ OTHER (Specify):

2. ORIGINAL MATERIAL
   - TYPE OF SPECIMEN (SPECIFY SITE OF COLLECTION):
   - DATE AND TIME OF COLLECTION:
   - TRANSPORTMEDIUM :
   - SWABBED BY RN/LPN/CNA (PRINT NAME)

3. SEROLOGY OF SPECIMEN
   - COLLECTION DATE:
   - ☐ ACUTE (S1): ____
   - ☐ CONVALESCENT (S2): ____
   - ☐ S3: ____
   - ☐ S4: ____
   - ☐ OTHER (Specify): ____

4. SEROLOGY OF SPECIMEN
   - ☐ PURE ISOLATE
   - ☐ MIXED CULTURE
   - ☐ OTHER (Specify):

DATE OF ORIGINAL CULTURE:
PRIMARY ISOLATON MEDIA:
COLLECTON SITE OF ORIGINAL SPECIMEN:

DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED:

SUSPECTED IDENTIFICATION:

OTHER ORGANISMS FOUND:

OTHER INFORMATION:

Appt date:
☐ Individual is a close contact; seek quarantine guidance from Containment Branch.
☐ Not a close contact.

III. CLINICAL HISTORY

1. CLINICAL SIGNS AND SYMPTOMS
   - ☐ FEVER
   - ☐ EXANTHEMA (Specify Type):
   - ☐ RESPIRATORY SIGNS:
   - ☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT:
   - ☐ GASTROINTESTINAL INVOLVEMENT:

2. ADDITIONAL INFORMATION
   - TRAVEL HISTORY: ☐ Yes ☐ No
   - SPECIFY:

IMMUNIZATIONS: ☐ Yes ☐ No

		Date		Date
☐ Pfizer	1st Dose	____	2nd Dose	____
☐ Moderna	1st Dose	____		____
☐ Johnson & Johnson			Single Dose	____
☐ Other____	1st Dose ____		2nd Dose	____

ANTIBIOTIC THERAPY:

3. PREVIOUS LABORATORY RESULTS/OTHER

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

Assay:

Result:

Reference: Negative or Not Detected

DATE OF REPORT: ____ INITIAL OF STAFF PERFORMING TEST: ____

Patient Last Name: ____________________________ Patient First Name: ________________________
Date of Birth: ___________________

COVID-19 Form for Testing/Outreach/Mass Screening

Date of onset: _______(*if symptomatic*) Date of travel:_______(*if history stated)*

During this illness, did the patient experience any of the following symptoms?

SYMPTOMS	YES	NO
Fever >100.4F (38C)	☐	☐
Subjective fever (felt feverish)	☐	☐
Chills/Rigors	☐	☐
Muscle aches (myalgias)	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Loss of sense of smell or taste or appetite	☐	☐
Headache	☐	☐
Fatigue/weakness	☐	☐
Cough (new or worsening)/Wheezing	☐	☐
Shortness of breath	☐	☐
Difficulty Breathing	☐	☐
Chest Pain	☐	☐
Nausea or vomiting	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Other (specify):	☐	☐

Does the patient have any pre-existing medical conditions?

CONDITION	YES	NO
Diabetes mellitus	☐	☐
Hypertension only (high blood pressure)	☐	☐
Cardiovascular disease	☐	☐
Chronic renal disease (ESRD/CRI)	☐	☐
Chronic liver disease	☐	☐
Chronic lung disease (asthma, emphysema, COPD)	☐	☐
Immunocompromised condition (cancer, chemo, lupus, HIV etc).	☐	☐
Neurological/neurodevelopmental/intellectual disability	☐	☐
Current Smoker	☐	☐
Former smoker	☐	☐
Pregnant	☐	☐
Other (specify):	☐	☐

Contact with another lab-confirmed COVID-19 patient? Yes ☐ No ☐ Index:_________________

Type of Contact: □ Household □ Community □ Workplace □ Healthcare
Has the Patient ever tested positive for COVID-19? Yes ☐ No ☐ Date of collection:________

Name of Interviewer: Last ______________________________ First _____________________________

Date of Interview: ______________________