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Test Request Form
COVID-19 SARS-CoV-2 RT-PCR

Patient Details [BLOCK CAPITALS PLEASE]

Patient Status: ☐ **Hospitalised** ☐ **At home** ☐ **ICU** ☐ **Care Home** ☐ **Deceased**

Surname: _____ Forename: _____

Patient Address: _____

City: _____ Eircode: ___ ___ ___ ___ ___ ___

DOB: ___ ___ ___ ___ ___ ___ ___ ___ Gender: Male ☐ Female ☐

MRN: _____ Sample ID: _____

At least one phone number is ESSENTIAL for contact tracing purposes:

Mobile No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Landline: ___ ___ ___ ___ ___ ___ ___ ___ ___

Occupation: _____ Name of workplace: _____

Address of workplace: _____

Does patient live in a Residential Facility? ☐ YES ☐ NO ☐ UNKNOWN

If YES, please specify type: _____ Residential Facility ID no.: _____

Name of Residential Facility: _____

Requesting Physician [BLOCK CAPITALS PLEASE]

Surname: _____ Forename: _____

Name of Clinic/Hospital: _____

Department/ Ward: _____

Address: _____

City: _____ Eircode: ___ ___ ___ ___ ___ ___

Phone numbers are ESSENTIAL for rapid reporting of POSITIVE results:

Tel: _____ Fax: _____

Date sample was taken: ___ ___ ___ ___ ___ ___ ___ ___ **Time:** ___ ___ ___ ___

Please ensure the sample vial is labelled.

Request for Analysis

Test Name	Code	Select
COVID-19 SARS-CoV-2 RT-PCR	DCOVP	☐

Eurofins Biomnis, Three Rock Road, Sandyford Business Estate, Dublin 18.
Phone: (01) 295 8545 Fax: (01) 295 5399 Email: salesdept@eurofins.ie Web: www.eurofins.ie/biomnis
Form RQF 1175 Issue No. 1.08 Active Date: 16/10/20

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COVID-19 SARS-CoV-2 RT-PCR

Clinical Details

- Is the patient symptomatic: ☐ YES ☐ NO ☐ UNKNOWN
- Date of onset of symptoms (if known): __ __ __ __ __ __ __ __

Please tick all that apply:

Symptoms	YES	NO	UNKNOWN
Cough	☐	☐	☐
Shortness of breath	☐	☐	☐
Fever	☐	☐	☐
Sore Throat	☐	☐	☐
Runny/Stuffy nose	☐	☐	☐
Loss of taste	☐	☐	☐
Loss of smell	☐	☐	☐

Symptoms	YES	NO	UNKNOWN
Diarrhoea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Aches and pains	☐	☐	☐
Tiredness	☐	☐	☐
Headaches	☐	☐	☐
Other	☐	☐	☐
If other, specify:			

- Date patient was placed in isolation (if applicable): __ __ __ __ __ __ __ __
- Was the patient hospitalised? ☐ YES ☐ NO ☐ UNKNOWN

  Date of admission: __ __ __ __ __ __ __ __
- Was the patient admitted to ICU? ☐ YES ☐ NO ☐ UNKNOWN

  Date of admission: __ __ __ __ __ __ __ __
- Name of Hospital: _____

Underlying Conditions ☐ YES ☐ NO ☐ UNKNOWN

Please tick all that apply:	YES
Chronic heart disease	☐
Hypertension	☐
Chronic neurological disease	☐
Chronic respiratory disease	☐
Chronic kidney disease	☐
Chronic liver disease	☐
Asthma requiring medication	☐
Immunodeficiency, including HIV	☐
Diabetes	☐
BMI >= 40	☐
Cancer / Malignancy	☐

- Is the patient pregnant? ☐ YES ☐ NO ☐ UNKNOWN
- Is the patient a smoker? ☐ YES ☐ NO ☐ UNKNOWN

- Other co-morbidities please specify:

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Occupational Healthcare Exposure Status

• **Is the patient currently employed as a Healthcare Worker (HCW)?** ☐ YES ☐ NO ☐ UNKNOWN

If YES, please specify role:

Nurse	☐	Pharmacy worker	☐	Cleaning/household staff	☐
Doctor	☐	Radiographer	☐	Catering\Kitchen worker in healthcare facility	☐
Physiotherapist	☐	Healthcare assistant	☐	Homecare	☐
Occupational therapist	☐	Medical student/ Student Doctor	☐	Admin\Clerical worker in healthcare facility	☐
Speech and language Pathologist	☐	Student Nurse	☐	Other	☐
Dietician	☐	Porter	☐	If other, specify:	

If YES, please specify TYPE OF HEALTHCARE FACILITY:

Acute hospital	☐	Prison	☐	Community Hospital/Long Term Stay Unit	☐
Hospice	☐	Homeless Facility - hub/hostel/hotel	☐	Women/Children's Refuge Facility	☐
GP Surgery	☐	Direct Provision Centre	☐	Centre for Adults and Children with Disabilities	☐
Nursing Home	☐	Mental Health Facility	☐	Other	☐
Testing site or Assessment hub for COVID-19	☐	Community Services	☐	If other, please specify:	

• Name of Healthcare Facility where employed _____

• Address of Healthcare Facility where employed _____

Occupational Healthcare Exposure Status

• Is appropriate PPE Available in the healthcare facility where you work? ☐ YES ☐ NO ☐ UNKNOWN

• Are you a HCW who has direct contact with patients/residents with confirmed/suspected COVID-19? ☐ YES ☐ NO ☐ UNKNOWN

• **If YES**, appropriate use of the following PPE as per your workplace guidance:

PPE	Always (100% of time)	Often (>50% of time)	Infrequent (<50% of time)	Never
Mask	☐	☐	☐	☐
FFP2/FFP3	☐	☐	☐	☐
Eye protection	☐	☐	☐	☐
Gloves	☐	☐	☐	☐
Gown	☐	☐	☐	☐

• **If PPE not always used (i.e. 100%):**

Date first contact with case: __ __ __ __ __ __

Date last contact with case: __ __ __ __ __ __

• When in contact with patients/residents with confirmed/suspected COVID-19, did you perform an Aerosol Generating Procedure? ☐ YES ☐ NO ☐ UNKNOWN

• If **YES**, details of aerosol generating procedures: _____

• Was FFP2/FFP3 mask used during procedure? ☐ YES ☐ NO ☐ UNKNOWN

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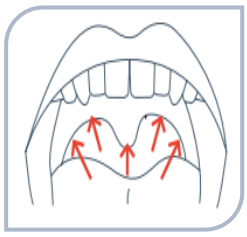
Sampling Instructions
COVID-19 SARS-CoV-2 RT-PCR

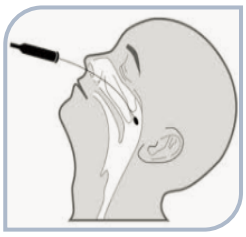
EUROFINS BIOMNIS COVID-19 RT-PCR COLLECTION KIT CONTENTS

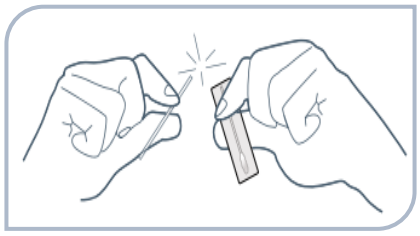
- Test request form and instructions
- 1 x swab (a long cotton bud)
- 1 x vial with a liquid medium
- 1 x biohazard bag

SAMPLE COLLECTION INSTRUCTIONS FOR THROAT AND NOSE

1. Wipe the soft tip of the swab around the back of the patient's throat (see fig. 1).
2. Then insert the swab into the nostril, parallel to the palate. The swab should reach a depth equal to the distance from the nostrils to the outer opening of the ear.
3. Submerge the swab in the transport medium. This is a lysis buffer which renders the sample safe (see fig. 3).
4. Break the stem manually to have a clean cut in order to seal properly the cap.
5. PLEASE ENSURE THE CAP IS SECURELY TIGHTENED TO AVOID LEAKAGE.







PACKING AND TRANSPORT PROCEDURE

1. Place the vial containing the swab into the correct pouch of the biohazard bag provided and seal the zip lock.
2. Put the folded test request form in the outer pouch of the biohazard bag.
3. Put the biohazard bag into the yellow specimen bag, intended exclusively for the packing and transport of SARS-CoV-2 RT-PCR samples to Eurofins Biomnis.
4. The bag is collected by the courier who will transport them in an ADR approved container to the laboratory.

IMPORTANT:

- UNDER **NO CIRCUMSTANCES** SHOULD THE SWAB BE DIPPED INTO THE VIAL **BEFORE** SWABBING THE PATIENT. **THIS WILL HARM THE PATIENT**. THE SWAB MUST BE BROKEN INTO THE VIAL ONLY **AFTER** SWABBING THE PATIENT. PLEASE ENSURE THE CAP ON THE VIAL IS SECURELY CLOSED.
- PLEASE ENSURE THAT THE TEST REQUEST FORM INCLUDES A CONTACT PHONE NUMBER FOR REPORTING RESULTS.
- SAMPLES WITHOUT APPROPRIATE PAPERWORK WILL NOT BE TESTED OR TESTING WILL BE DELAYED.

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