



Public Health
Prevent. Promote. Protect.

Santa Cruz County

**Public Health Division
Communicable Disease**



County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1060 EMELINE AVE., SANTA CRUZ, CA 95061
TELEPHONE: (831) 454-4114 FAX: (831) 454-5049 TDD: Call 711

COVID-19 SUBMITTAL FORM FOR PUBLIC HEALTH LAB TESTING

Instructions:

1. Once you suspect COVID-19, complete [CDC PUI Form](#) and FAX to (831) 454 – 5049 or E-Mail HSACD@santacruzcounty.us. If after hours, call (831) 471-1170 to speak with the Health Officer for review.
2. If you don't hear back soon, call (831) 454-4114 to confirm receipt and find out if specimens should be collected (if so, see instructions below).
3. If approved, [Collect specimens](#) as recommended by the CDC Nasopharyngeal Swab and include a hard copy of this form and the CDC PUI Form. Also, FAX or E-Mail this form to the contact information in step 1.

PATIENT INFORMATION

Patient's Name (Last, First):	DOB:	AGE:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	PREGNANT? <input type="checkbox"/> No (or N/A) <input type="checkbox"/> Yes, EDD:
Mailing Address (include ZIP code):	ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____		PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish, but speaks English? <input type="checkbox"/>
	Phone #:			Alternate Phone #:

SPECIMEN INFORMATION

Type of Specimen: <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Other: _____	Date of Specimen Collection:	Was this patient tested for influenza test? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, the result was: <input type="checkbox"/> Positive <input type="checkbox"/> Negative - If positive, was subtype identified? <input type="checkbox"/> Flu A <input type="checkbox"/> Flu B <input type="checkbox"/> Not typed
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PROVIDER INFORMATION

PROVIDER NAME:	PROVIDER OFFICE ADDRESS:	PROVIDER PHONE #:	PROVIDER FAX #:
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RESULTS WILL BE SENT TO: SANTA CRUZ COUNTY CD UNIT AT FAX: (831) 454-5049
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