NC Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION LAB PROVIDERS:
This form is only for reporting positive results. Report aggregate positives AND negatives through the Electronic COVID-19 Aggregate Test Report (eCATR) survey. Asterisk (*) denotes required items. Fax results to your State (919) 733-0490 OR local health department.

COVID-19 Positive Antigen Lab Test Report

*Patient First Name
*Patient Last Name
*Patient Birthdate *(mm/dd/yyyy):* / /

ATTENTION Local Health Department Staff. Enter all information from this form into the NC COVID question packages.

Patient Demographics

Patient Salutation	*Patient First Name *(no digits)*	Patient Middle Name *(no digits)*	*Patient's Last Name *(no digits)*	Suffix

*Birthdate *(mm/dd/yyyy):* / /	Patient Street Address

*City	*State	*ZIP	*County	*Phone
				( ) -

Email	*Gender:	*Patient Race:
	☐ Male ☐ Female ☐ Male to Female ☐ Female to Male	☐ Native American or Alaskan Native ☐ Asian ☐ Black of African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Unknown

*Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Patient Identifier (MRN or other):

Ordering Provider Info

*Provider First Name	Provider Middle Name	*Provider Last Name	Provider Suffix

*Provider Street Address	*Provider City	*Provider State	*Provider ZIP	*Provider County

Provider NPI:	Provider Phone ( ) -

Lab Results

*Specimen Collection Date *(mm/dd/yyyy):* / /	Specimen Collection Time *(hh:mm):* ☐am ☐pm	*Received Date: / /	*Test Name:
			☐ Abbott BiNAXNow COVID AgCard ☐ BD Veritor System ☐ Quidel Sofia 2 ☐ Sampinute Antigen MIA ☐ CareStart Antigen Test ☐ LumiraDx Ag Test ☐ Other:

*Specimen Type: ☐ Nasopharyngeal swab ☐ Nasal swab		
*Result *(This form is only for reporting positive results.)* ☐ Positive ☐ Negative ☐ Invalid Result	*Result Date: / /	* Result Status ☐ Final ☐ Corrected

Ordering Lab Info

*Ordering Lab Name	*CLIA Number:	*Lab Phone
		( ) -

*Lab Street Address	*Lab City	*Lab State	*Lab ZIP	*Lab County

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COVID-19 Positive Antigen Lab Test Report

*Patient First Name
*Patient Last Name
*Patient Birthdate *(mm/dd/yyyy):* / /

Ordering Facility Info (if different than Ordering Lab)

*Ordering Facility Name		*Facility Phone ( ) -		
*Facility Street Address	*Facility City	*Facility State	*Facility ZIP	*Facility County

Ask On Order

*Symptomatic: Yes No Unknown	Symptom Onset Date: / /	
*Employed in Healthcare? Yes No Unknown	*ICU? Yes No Unknown	*First Test? Yes No Unknown
*Hospitalized? Yes No Unknown	*Pregnant? Yes No Unknown	*Congregate Care Setting? Yes No Unknown

Comments: