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Executive Deputy Commissioner

April 9, 2020

TO: Healthcare Providers, Healthcare Facilities, Clinical Laboratories, and Local Health Departments
FROM: New York State Department of Health (NYSDOH)

HEALTH ADVISORY: NOVEL CORONAVIRUS DISEASE (COVID-19)

Updated Infection Disease Requisition Form for Collection of Demographic Information

SUMMARY

- Wadsworth Center has released an updated Infectious Disease Requisition (IDR) form to improve the understanding of demographic patterns of COVID-19 infections.
- Laboratories should ensure their order requisition forms include information on both patient sex/gender identity and race/ethnicity, as well as communicate the importance of completing this information to ordering providers.

COLLECTION OF DEMOGRAPHIC INFORMATION

- Due to growing concerns about potential disparate health impacts related to COVID-19, and in order to inform the development of interventions to address any potential disparities, it is important that demographic information is collected at the time of COVID-19 testing.
- To address these concerns, Wadsworth Center has updated the IDR form to include race and ethnicity information. Healthcare providers sending specimens for testing to Wadsworth Center must use the updated IDR form going forward.
- To further the development of critical clinical and public health interventions for COVID-19, **it is essential that ordering healthcare providers complete all fields** to the best of their ability when completing any laboratory requisition form, including the sections on sex/gender identity and race/ethnicity.
- Healthcare providers must collect accurate sex and/or gender identity information when ordering a COVID-19 test, including for patients who identify as transgender and/or gender non-conforming. Where possible, gender identity information should be collected in a manner consistent with the patient's gender identity by asking a patient "Do you identify yourself as male, female, transgender or gender non-conforming?" If it is not possible to document gender identity information in a manner consistent with the patient's gender identity due to limitations in reporting forms or protocols (e.g., the laboratory order form limits options to "male," "female," and "other") healthcare providers should consult with the patient about the person's gender identity to ensure it is collected as accurately as possible.
- Clinical laboratories should also ensure their laboratory order requisition forms are updated to include information on patient sex/gender identity and race/ethnicity if they do not already include these demographics. Where possible, requisition forms for COVID-19 testing should allow for the accurate collection of sex and gender identity information, including for transgender and/or gender non-conforming patients.

RESOURCES

NYSDOH COVID-19 Website
CDC COVID-19 Website
NYS Local Health Department Directory
World Health Organization (WHO) COVID-19 Website

NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Infectious Diseases Requisition

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: Courier Address: 5668 State Farm Rd, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to: https://www.wadsworth.org/programs/id

Patient Demographics and Requesting Provider

*required information

Last name* | First name* | MI | DOB* / / | ☐ Male ☐ Other ☐ Female

Permanent Street Address | Facility of Residence (if applicable) | City | State | Zip Code

NYS County of Residence* | Patient Reference Number | NYS DOH Outbreak Number | CDESS Case Number

*Race (Select one or more) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

*Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Name and National Provider Identifier (NPI) for Health Care Provider: Phone: ( ) –

Submitting Facility (Laboratory report will be sent to this address)

*required information

Name* | Laboratory PFI

Address* | NPI

Contact Person* | Phone* ( ) –

Specimen Information

*required information

Collection Date*: / / | Time Collected (if applicable): | Date of Symptoms Onset: / / | ☐ Autopsy

Source(s)*	Specimen submitted on/in (specify media/preservative/cell line)		Submitter's Specimen Identifier(s)
		☐ Isolate ☐ Primary	
		☐ Isolate ☐ Primary	
		☐ Isolate ☐ Primary	

Laboratory Examination Requested

☐ Confirmation ☐ Identification/Detection Submitter Lab Findings: Smear/Stain/Other:

Suspect Organism/Agent

☐ **Bacterial** ______
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other Susceptibility (please specify): ______

☐ **Fungal** ______
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other Antifungal Susceptibility

☐ **Mycobacterial** ______

Suspect Organism/Agent

☐ **Parasitic** ______
- ☐ Malaria Drug Susceptibility

☐ **Serology** ______

☐ **Viral**** ______
- ☐ Viral Encephalitis PCR Panel on CSF
- ☐ Influenza Antiviral Susceptibility

☐ **Other** ______

Clinical History

☐ Health Care Worker ☐ Donor Screening Relevant Exposure: ☐ Travel ☐ Animal ☐ Arthropod ☐ Contact w/ Known Case ☐ Food/Water

Exposure Detail: | Hospitalized: ☐ Yes ☐ No | Hospital Name:

Diagnosis: | Pregnant (trimester): | Fever (max): | CSF: Glu____ Prot____ RBC____ WBC____

Relevant Treatment: | Date: / / | Relevant Immunization: | Date: / /

****Symptoms** (check all applicable): ☐ Acute ☐ Chronic ☐ Other Symptoms ______

Cardiovascular	Central Nervous System	Rash	Respiratory	Miscellaneous	
☐ Endocarditis	☐ Altered Mental Status	☐ Hemorrhagic	☐ Bronchitis	☐ Arthralgia	☐ Lymphadenopathy
☐ Myocarditis	☐ Encephalitis	☐ Maculopapular	☐ Cough	☐ Conjunctivitis	☐ Malaise
☐ Pericarditis	☐ Headache	☐ Petechial	☐ Pneumonia	☐ Hepatitis	☐ Myalgia
	☐ Meningitis	☐ Vesicular	☐ Upper Respiratory	☐ Hepatomegaly	☐ Splenomegaly
	☐ Paralysis			☐ Immunocompromised	

NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Non-Human Samples

Please send specimen(s) to: New York State Department of Health, Wadsworth Center

Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: Courier Address: 5668 State Farm Rd, Slingerlands, NY 12159

Submitter (test ordered by)

*required information

Name*:

Address*:

Contact Person*: Phone*: ( ) –

Sample Information

Collection Date*: / / Rabies Lab Only Second Collection Date: / /

NYSDOH Outbreak Number:

Collection Site:

Street Address:

City: State: Zip Code: NYS County:

Laboratory Examination Requested

☐ Bacterial ☐ Fungal ☐ Mycobacterial ☐ Parasitic ☐ Serology ☐ Viral ☐ Other

Suspect Organism/Agent:

Animal

☐ Domestic ☐ Wild

☐ Avian ☐ Mammal ☐ Reptile ☐ Other

Common Name or Species:

Submitter Sample Number: Sample Source:

Domestic Animal Owner Name: Animal Name:

Comments:

Food

Brand Name:

Lot Number: USDA Number: Sell By Date: / /

Sample Description:

Comments:

Environmental

Source Description:

Describe below samples taken; use separate sheets if necessary.

Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)	Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)

Comments: