Column Name in CSV	Corresponding Field in Form	Location of Field on Form	Instructions for Entry	Example	Required Field	Additional Comments
Collection_Date	Collection Date	Specimen Information	Date in mm/dd/yyyy format	09/11/2020	Y	
Order_Date	Order Date	Specimen Information	Date in mm/dd/yyyy format	09/10/2020	Y	
Patient_First_Name	Patient Name First	Patient Information	Text	John	Y	Must match patient name on specimen collection tube
Patient_Middle_Initial	Patient Name MI	Patient Information	Text	X	Y	Must match patient name on specimen collection tube
Patient_Last_Name	Patient Name Last	Patient Information	Text	Doe	Y	Must match patient name on specimen collection tube
Date_of_Birth	Date of Birth	Patient Information	Date in mm/dd/yyyy format	05/24/1983	Y	Must match patient name on specimen collection tube
Symptomatic	Symptomatic	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = patient is symptomatic at time of specimen collection No = patient is not symptomatic at time of specimen collection Unknown = unsure if patient is symptomatic at time of specimen collection	Yes	Y	
Symptom_Onset_Date	Onset Date	Specimen Information	Date in mm/dd/yyyy format only if Symptomatic = "Yes"	09/08/2020	Y	
Sex_Female	Sex	Patient Information	Enter only 1 option: Yes or No Yes = patient is female No = patient is male	No	Y	
Sex_Male	Sex	Patient Information	Enter only 1 option: Yes or No Yes = patient is male No = patient is female	Yes	Y	
Address	Address	Patient Information	Text	8995 E Main St	Y	Should be patient's home address; no PO Box addresses; no facility addresses unless patient lives at facility
County	County	Patient Information	Text	Licking	Y	Should be county corresponding to patient's address
City	City	Patient Information	Text	Reynoldsburg	Y	Should be city corresponding to patient's address
State	State	Patient Information	Text (2 letter abbreviation)	OH	Y	Should be state corresponding to patient's address
Zip	Zip	Patient Information	5 digit numeric code	43068	Y	Should be ZIP code corresponding to patient's address
Patient_Phone_Number	Phone Number	Patient Information	10 digit numeric sequence in (xxx) xxx-xxxx format	(614) 867-5309	Y	Should include 3 digit area code
Patient_ID	Chart or Patient ID	Patient Information	Text or numeric code	Z135481	Y	Please do not include SSN here
Race_White	Race White	Patient Information	Enter only 1 option: Yes or No Yes = patient is White No = patient is not White	Yes	Y	Can have "Yes" selected for more than 1 race group
Race_Black_African_American	Race Black/African American	Patient Information	Enter only 1 option: Yes or No Yes = patient is Black/African American No = patient is not Black/African American	Yes	Y	Can have "Yes" selected for more than 1 race group
Race_Asian	Race Asian	Patient Information	Enter only 1 option: Yes or No Yes = patient is Asian No = patient is not Asian	No	Y	Can have "Yes" selected for more than 1 race group
Race_Native_Hawaiian	Race Native Hawaiian/Pacific Islander	Patient Information	Enter only 1 option: Yes or No Yes = patient is Native Hawaiian/Pacific Islander No = patient is not Native Hawaiian/Pacific Islander	No	Y	Can have "Yes" selected for more than 1 race group
Race_American_Indian	Race American Indian/Alaskan Native	Patient Information	Enter only 1 option: Yes or No Yes = patient is American Indian/Alaskan Native No = patient is not American Indian/Alaskan Native	No	Y	Can have "Yes" selected for more than 1 race group
Race_Other	Race Other	Patient Information	Enter only 1 option: Yes or No Yes = patient is an other race, not already specified No = patient is not an other race	No	Y	Can have "Yes" selected for more than 1 race group
Race_Other_Specify	Race Other	Patient Information	Text only Race_Other = "Yes"		Y	
Ethnicity_Hispanic	Ethnicity Hispanic	Patient Information	Enter only 1 option: Yes or No Yes = patient is Hispanic No = patient is not Hispanic	No	Y	
Ethnicity_Non_Hispanic	Ethnicity Non-Hispanic	Patient Information	Enter only 1 option: Yes or No Yes = patient is not Hispanic No = patient is Hispanic	Yes	Y	
ODH_Outbreak_Number	ODH Outbreak #	Specimen Information	Text			
Patient_Type_Resident	Congregate Care Patient Type Resident	Specimen Information	Enter only 1 option: Yes or No Yes = patient is a nursing home resident No = patient is not a nursing home resident	No		
Patient_Type_Staff	Congregate Care Patient Type Staff	Specimen Information	Enter only 1 option: Yes or No Yes = patient is a nursing home staff member No = patient is not a nursing home staff member	Yes		
First_COVID_Test	First Test	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = this is the first SARS-CoV-2 test for this patient No = this is not the first SARS-CoV-2 test for this patient Unknown = unsure if this is the first SARS-CoV-2 test for this patient	No	Y	
Employed_Healthcare	Employed in Healthcare	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = patient is employed in healthcare No = patient is not employed in healthcare Unknown = unsure if patient is employed in healthcare	Yes	Y	
Hospitalized	Hospitalized	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = patient is hospitalized at the time of this specimen collection No = patient is not hospitalized at the tme of this specimen collection Unknown = unsure if patient is hospitalized at the time of this specimen collection	No	Y	
ICU	ICU	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = patient is in the ICU at the time of this specimen collection No = patient is not in the ICU at the tme of this specimen collection Unknown = unsure if patient is in the ICU at the time of this specimen collection	No	Y	
Pregnant	Pregnant	Specimen Information	Enter only 1 option: Yes, No, or Unknown Yes = patient is pregnant at the time of this specimen collection No = patient is not pregnant at the tme of this specimen collection Unknown = unsure if patient is pregnant at the time of this specimen collection	No	Y	

Submitter_Name	Agency Name	Submitter Information	Text	Ohio Department of Health Laboratory	Y	
Submitter_Point_of_Contact	Contact Name	Submitter Information	Text	OMIS	Y	Must be able to answer questions from testing laboratory on patient demographic information and specimen collection information
Submitter_Fax_Number	Secure Fax Number	Submitter Information	10 digit numerical sequence in (xxx) xxx-xxxx format	(614) 387-1505	Y	Should include 3 digit area code
Submitter_Phone_Number	Phone Number	Submitter Information	10 digit numerical sequence in (xxx) xxx-xxxx format	(614) 728-1123	Y	Should include 3 digit area code
Submitter_Address	Address	Submitter Information	Text	8995 E Main St	Y	
Submitter_City	City	Submitter Information	Text	Reynoldsburg	Y	
Submitter_State	State	Submitter Information	Text (2 letter abbreviation)	OH	Y	
Submitter_Zip	Zip	Submitter Information	5 digit numeric code	43068	Y	
Facility_License_Number	ODH Facility License #	Specimen Information	Text	0542N		
Specimen_Type_NP_Swab	Nasopharyngeal (NP) swab	Specimen Site	Enter only 1 option: Yes or No Yes = specimen was collected from the nasopharynx No = patient was not collected from the nasopharynx	No	Y	
Specimen_Type_OP_Swab	Oropharyngeal (OP) swab	Specimen Site	Enter only 1 option: Yes or No Yes = specimen was collected from the oropharynx No = patient was not collected from the oropharynx	No	Y	
Specimen_Type_Other	Other swab	Specimen Site	Enter only 1 option: Yes or No Yes = specimen was collected from another upper respiratory site No = patient was not collected from another upper respiratory site	Yes	Y	Should be "Yes" if specimen type collected was a nasal swab
Specimen_Type_Other_Specify	Other swab	Specimen Site	Text	Nasal		Should be "Nasal" if specimen type collected was a nasal swab
Patient_Uninsured	Uninsured	Insurance Information	Enter only 1 option: Yes or No Yes = patient is uninsured No = patient is insured	No		Should only be marked "Yes" if patient is uninsured
Insured_First_Name	Insured Name First	Insurance Information	Text	John	Y	To be filled out only if patient is insured
Insured_Middle_Initial	Insured Name MI	Insurance Information	Text	X		To be filled out only if patient is insured
Insured_Last_Name	Insured Name Last	Insurance Information	Text	Doe	Y	To be filled out only if patient is insured
Social_Security_Number	Social Security Number	Insurance Information	9 digit numeric sequence in xxx-xx-xxxx format	000-00-0000	Y	To be filled out only if patient is insured
Name_of_Insurance_Company	Name of Insurance Company	Insurance Information	Text	Medical Mutual	Y	To be filled out only if patient is insured
InsuranceCo_Address	Insurance Address	Insurance Information	Text	1500 Lake Ave	Y	To be filled out only if patient is insured Address of insurance company as listed on insurance card
InsuranceCo_City	City	Insurance Information	Text	Cleveland	Y	To be filled out only if patient is insured Address of insurance company as listed on insurance card
InsuranceCo_State	State	Insurance Information	Text (2 letter abbreviation)	OH	Y	To be filled out only if patient is insured Address of insurance company as listed on insurance card
InsuranceCo_Zip	Zip	Insurance Information	5 digit numeric sequence	44035	Y	To be filled out only if patient is insured Address of insurance company as listed on insurance card
Insurance_ID_Number	Insurance ID Number (if not SSN)	Insurance Information	Text	6543212		To be filled out only if patient is insured
Insurance_Group_ID_Number	Group ID Number	Insurance Information	Text	153575	Y	To be filled out only if patient is insured
Ordering_Provider	Ordering Provider/Medical Director	Insurance Information	Text	Dr. Jones	Y	
Provider_NPI	NPI	Insurance Information	10 digit numeric sequence	8313215651	Y	National Provider Identifier
Provider_Phone	Ordering Provider Phone	Insurance Information	10 digit numeric sequence in (xxx) xxx-xxxx format	(614) 888-8888	Y	
Comments	Comments	Comments	Text			