



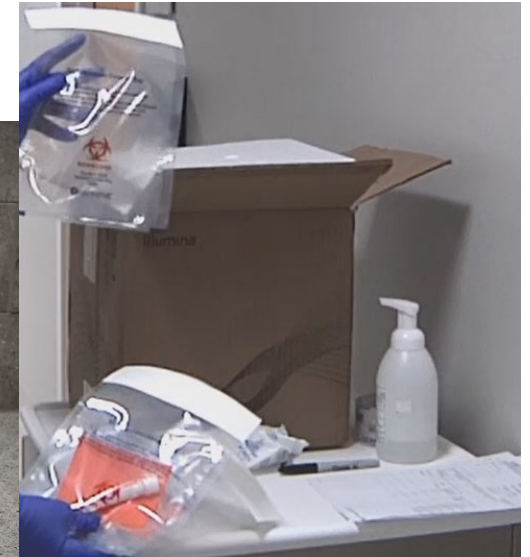
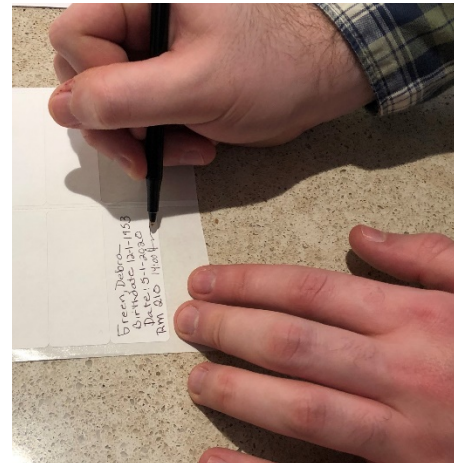
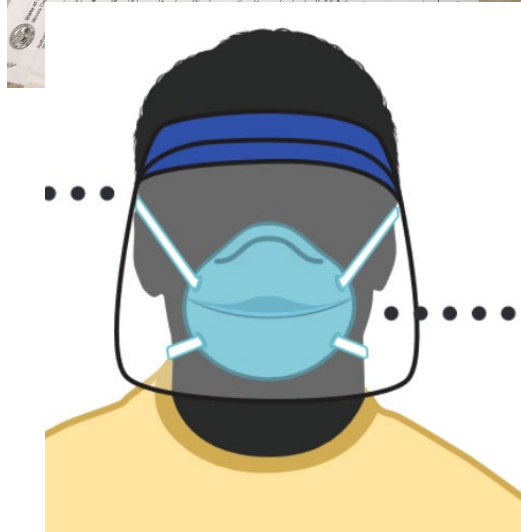
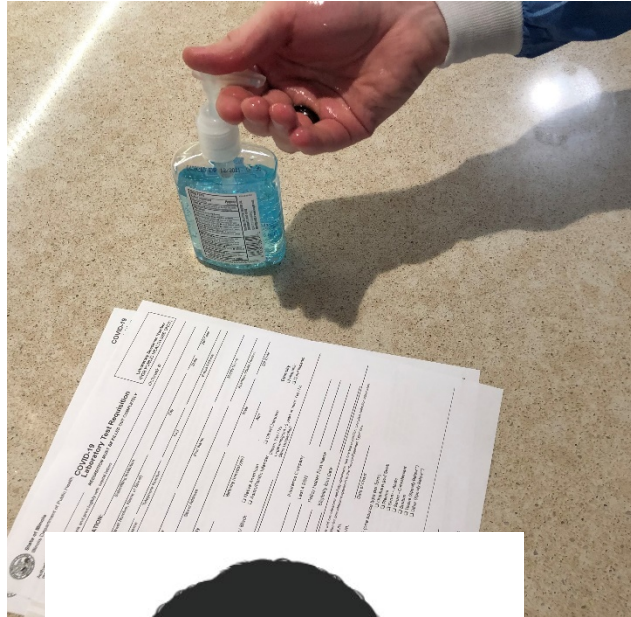
## ***COVID-19: Sample collection procedure***

**Deb Burdsall, PHD, RN-BC, CIC, FAPIC  
Karen Trimmerger, RN, MPH, NE-BC, CIC  
Angela Tang, MPH**

May 2020

# COVID 19 Testing

# Swabbing Preparation



# Clarify if Swabs are Going to QUEST or to IDPH Lab Locations

Revision 4/15/20



## COVID-19 specimen collection guidelines

Quest specimen requirements and acceptable supplies for SARS-CoV-RNA (COVID-19),  
Qualitative NAAT (test code 39448)

---

Illinois Department of Public Health  
Division of Laboratories  
2121 W. Taylor Street  
Chicago, IL 60612  
312-793-4760

Illinois Department of Public Health  
Division of Laboratories  
825 N. Rutledge Street  
Springfield, IL 62702  
217-782-6562

Illinois Department of Public Health  
Division of Laboratories  
1155 South Oakland Avenue  
Carbondale, IL 62901  
618-457-5131



## Swabbing Preparation: Team approach

- Nurses
- Recorder



# Swabbing Preparation: Set Up Cart

A cart to transport specimen collection supplies (one cart per team):

- One trash bag/cart
- Recommended PPE (e.g., gown, gloves, mask, eye protection)
- Alcohol based hand sanitizer
- Disinfectant wipes effective against SARS-CoV-2
- Testing supplies

A staging room (e.g., conference room) to convene before and after specimen collection

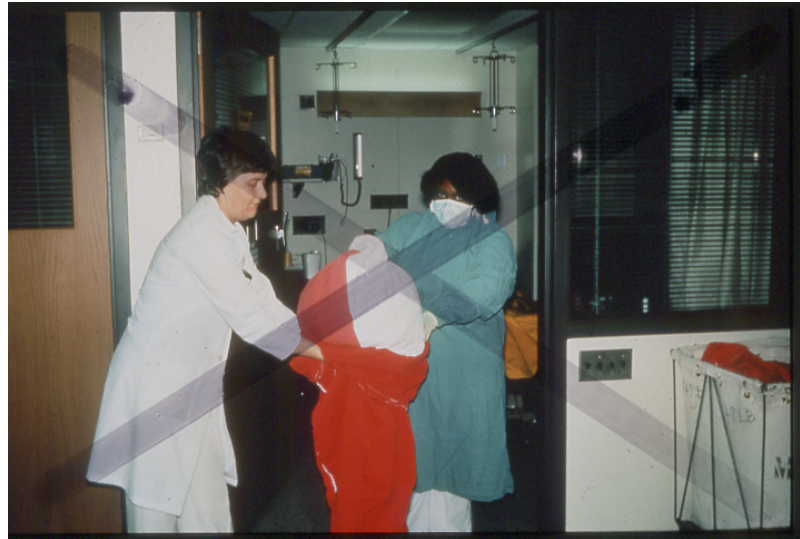
A separate area or room where staff can be tested



Cart  
Examples

# CDC Isolation Precautions Guidelines

- Do **Not** require or recommend for patients/residents on any precaution category
  - No special bag or process for linen
  - No double bagging trash or linen unless bag torn or soiled
  - No red bag collection of regular waste (includes non-bloody isolation trash)
  - No double gloving
  - No disposable dishes



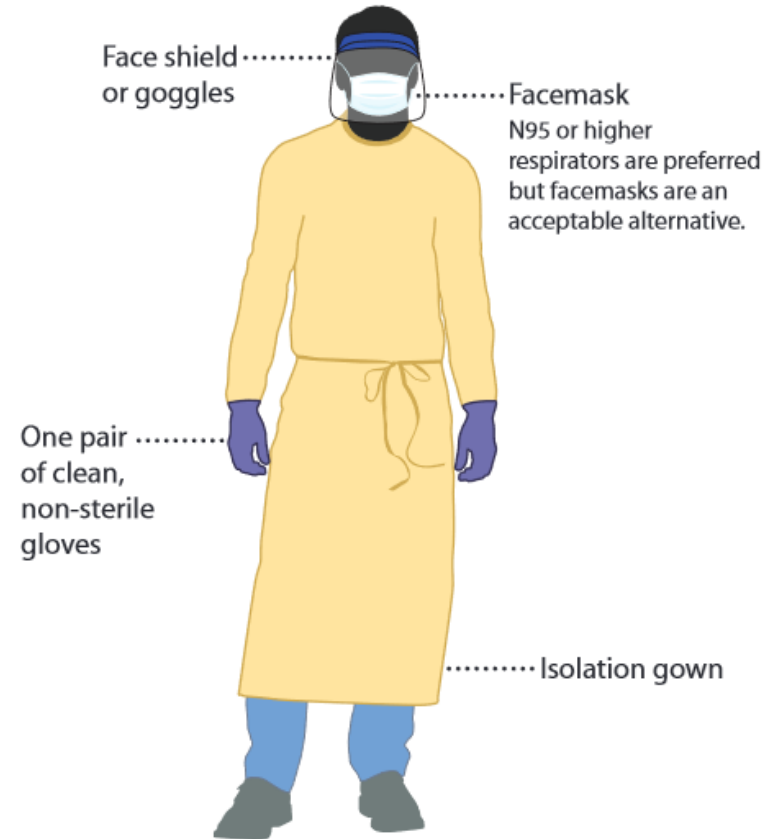
Slide Source: *Karen K. Hoffmann, RN, MS, CIC*

# COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel

## Preferred PPE – Use N95 or Higher Respirator



## Acceptable Alternative PPE – Use Facemask



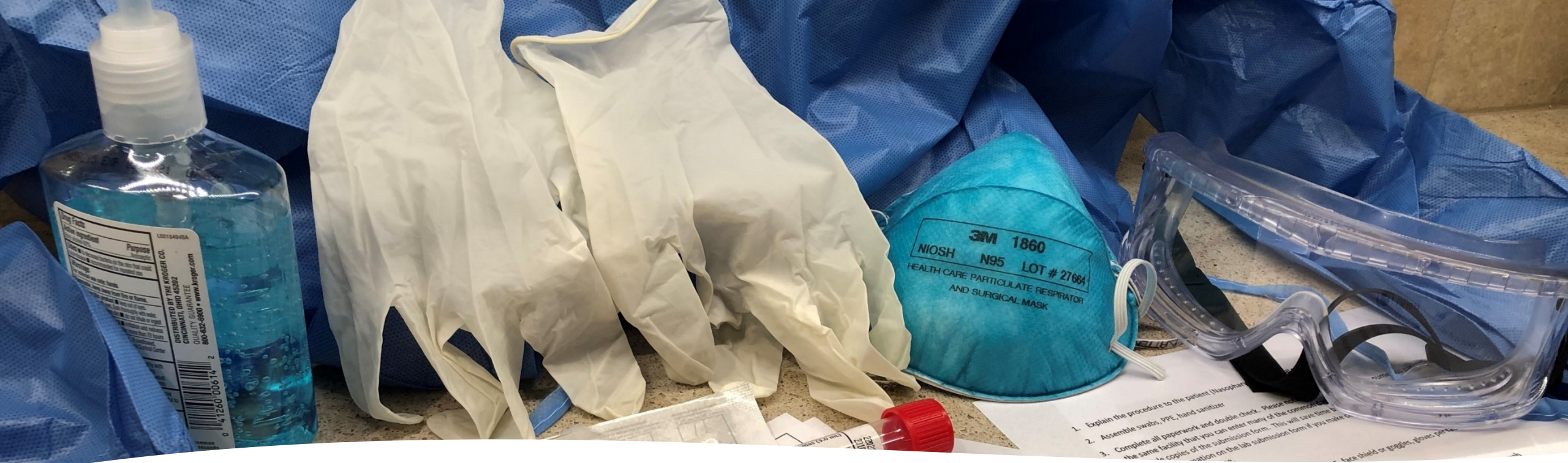
[cdc.gov/COVID19](https://www.cdc.gov/COVID19)







(Manuel Silvestri/Reuters)



## Swabbing Steps 1-2

1. Explain the procedure to the patient (Nasopharyngeal or Nasal swab)
2. Assemble swabs, PPE, hand sanitizer



# Swabbing Step 3

3. Recorder completes all paperwork and double checks.

If you are sampling numerous patients from the same facility

- enter many of the common data elements electronically
- print multiple copies of the submission form.

Saves time

Only need to complete patient specific information on the lab submission form if you make copies that have much of the information completed in advance.

Green, Debra  
Birthdate 12-1-1953  
Date: 5-1-2020  
PM 2:10 14:00

**State of Illinois**  
Illinois Department of Public Health

Authorization Code: \_\_\_\_\_  
Type or use middle dark ink and print legibly with capital letters

**COVID-19 Laboratory Test**  
REQUISITION MUST BE FILLED

**SUBMITTER INFORMATION:**

Submitter Name: \_\_\_\_\_  
Submitter Address (Street Number, Name of Street): \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

**PATIENT INFORMATION:**

Contact Person/Physician's Last Name: \_\_\_\_\_  
Patient's Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Race:  White  Black  Asian/Pacific Islander  Native American  Other (Specify Below)  
Sex:  Male  Female

**INSURANCE INFO**

Insurance Company: \_\_\_\_\_  
Last 4 SSN: \_\_\_\_\_  
Policy Holder Last Name: \_\_\_\_\_  
Policy Holder First Name: \_\_\_\_\_  
Eligibility Begin Date: \_\_\_\_\_  
Eligibility End Date: \_\_\_\_\_

**TEST REQUEST INFORMATION** When sending acute and convalescent serology specimens, use one test requisition form per specimen. When sending acute and convalescent serology specimens, use one test requisition form per specimen. When sending acute and convalescent serology specimens, use one test requisition form per specimen. When sending acute and convalescent serology specimens, use one test requisition form per specimen.

Date Collected (mm/dd/yyyy): \_\_\_\_\_ Time Collected: ( ) a.m. ( ) p.m.

**TEST REQUEST INFORMATION**

TEST: COVID-19

SOURCE/SPECIMEN TYPE (one source type per form)

Anterior Nares Swab  Oropharyngeal Swab  
 Blood - Serum  Plasma  
 Bronchial Alveolar Lavage "BAL"  
 Serum - Acute  Serum - Convalescent  
 Nasal Aspirate  Nasal Wash (Specify Below)  
 Nasopharyngeal Swab



# Test Requisition Form

- Must be submitted with each sample.
- Each lab has its own test requisition form. Contact the lab that will be doing your testing for the form.
- Following are examples from the IDPH Lab and Quest.





### COVID-19 Laboratory Test Requisition

Laboratory Specimen Number  
(FOR PUBLIC HEALTH USE ONLY)

Authorization Code: \_\_\_\_\_  
(if applicable)

REQUISITION MUST BE FILLED OUT COMPLETELY

Type or use indelible dark ink and print legibly with capital letters

Outbreak #: \_\_\_\_\_

**SUBMITTER INFORMATION:**

Submitting Institution \_\_\_\_\_

Submitter Address (Street Number, Name of Street) \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

Contact Person/Clinician's Last Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

FAX \_\_\_\_\_

E-mail Address \_\_\_\_\_

**PATIENT INFORMATION:**

Patient's Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Street Address \_\_\_\_\_

Apartment/Suite Number \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

Telephone Number \_\_\_\_\_

Birthdate (mm/dd/yyyy) \_\_\_\_\_

Age \_\_\_\_\_

**Sex**

- Male
- Female

**Race**

- White
- African American/ Black
- Native American
- Asian/Pacific Islander
- Other/Unknown

**Ethnicity**

- Hispanic
- Non-Hispanic

Patient ID # (optional) \_\_\_\_\_

**INSURANCE INFO**

Recipient ID # \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Social Security Number \_\_\_\_\_

Policy Holder Last Name \_\_\_\_\_ Policy Holder First Name \_\_\_\_\_

Eligibility Begin Date \_\_\_\_\_ Eligibility End Date \_\_\_\_\_

**TEST REQUEST INFORMATION** When sending acute and convalescent serology specimens, use one test requisition. Complete collection information immediately below for acute specimen and complete collection information for convalescent specimen in the "Source/Specimen Type" box.

Date Collected (mm/dd/yyyy) \_\_\_\_\_ Time Collected \_\_\_\_\_ ( ) a.m. ( ) p.m. Date of Onset \_\_\_\_\_

**TEST**

COVID-19

**SOURCE/SPECIMEN TYPE (one source type per form)**

- Anterior Nares Swab
- Blood - Serum
- Bronchial Alveolar Lavage "BAL"
- Mid-turbinate Nasal Swab
- Nasal Aspirate
- Nasal Washing
- Nasopharyngeal Swab
- Oropharyngeal Swab
- Plasma
- Serum - Acute
- Serum - Convalescent
- Sputum
- Tissue (Specify Below\*\*)
- Other (Specify Below\*\*)

\*\*SOURCE

If using the IDPH Laboratory, the form is available at:  
<http://dph.illinois.gov/sites/default/files/forms/idph-covid-laboratory-test-requisition20200521.pdf>



**COVID-19  
Laboratory Test Requisition**

Laboratory Specimen Number  
(FOR PUBLIC HEALTH USE ONLY)

Authorization Code: \_\_\_\_\_  
(# applicable)

REQUISITION MUST BE FILLED OUT COMPLETELY

Type or use indelible dark ink and print legibly with capital letters

Outbreak #: \_\_\_\_\_

**SUBMITTER INFORMATION:**

Submitting Institution: Long Term Care Facility  
 Submitter Address (Street Number, Name of Street): 123 Maple St.  
 City: Springfield State: IL ZIP Code: 62704  
 Contact Person/Clinician's Last Name: Dr. James Smith Telephone Number: 217-555-1234 FAX: 217-555-5678 E-mail Address: LTCF@yahoo.com

**PATIENT INFORMATION:**

Specimen  
 Patient's Last Name: Specimen First Name: John Middle Name: M  
 Street Address: 246 Douglas St. Apartment/Suite Number: Apt. C  
 City: Springfield State: IL ZIP Code: 62704  
 Telephone Number: 217-555-4321 Birthday (mm/dd/yyyy): 09/27/1968 Age: 51

Sex:  Male  Female  
 Race:  White  African American/ Black  Native American  Asian/Pacific Islander  Other/Unknown  
 Ethnicity:  Hispanic  Non-Hispanic

Patient ID # (optional): 462437

**INSURANCE INFO**

Recipient ID #: 12345 Insurance Company: Health Insurance, Inc.  
 Group/Policy #: 94678 Social Security Number: 123-45-6789  
 Policy Holder Last Name: Specimen Policy Holder First Name: John  
 Eligibility Begin Date: 4-27-2018 Eligibility End Date: 4-27-2021

**TEST REQUEST INFORMATION** When sending acute and convalescent serology specimens, use one test requisition. Complete collection information immediately below for acute specimen and complete collection information for convalescent specimen in the "Source/Specimen Type" box.

Date Collected (mm/dd/yyyy): 05/28/2020 Time Collected: 3:15 (  ) a.m. (  ) p.m.  
 Date of Onset: 05/26/2020

**TEST**

COVID-19

**SOURCE/SPECIMEN TYPE** (one source type per form)

- Anterior Nares Swab
- Blood - Serum
- Bronchial Alveolar Lavage "BAL"
- Mid-turbinate Nasal Swab
- Nasal Aspirate
- Nasal Washing
- Nasopharyngeal Swab
- Oropharyngeal Swab
- Plasma
- Serum - Acute
- Serum - Convalescent
- Sputum
- Tissue (Specify Below\*\*)
- Other (Specify Below\*\*)



**BILL TO:**  
 MY ACCOUNT  
 PATIENT  
 MEDICARE  
 RAILROAD MEDICARE  
 MEDICAID  
 Lab Card/Select  
 OTHER INSURANCE

**STAT**  
 **STAT PICK UP**

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE)      DATE OF BIRTH      M   M   D   D   YEAR      SEX

PATIENT SOCIAL SECURITY #      OFFICE / PATIENT ID #

ROOM #      LAB REFERENCE #      PATIENT PHONE #  
 (   )

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY)      APT. #      KEY #

CITY      STATE      ZIP

**Primary Insurance**     Medicare     Medicaid     Other

Patient Is:  
 Subscriber  
 Spouse  
 Other Dependent

Insurance Company Name \_\_\_\_\_

Insurance Member /ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Medicare/Medicaid # \_\_\_\_\_

**Secondary Insurance**     Medicare     Medicaid     Other

Patient Is:  
 Subscriber  
 Spouse  
 Other Dependent

Insurance Company Name \_\_\_\_\_

Insurance Member /ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Medicare/Medicaid # \_\_\_\_\_

**INSURANCE**

**DID YOU KNOW**

**Patient Service Center location and appointment scheduling information is on the back.**

**Each sample should be labeled with at least two patient identifiers at time of collection.**

ACCOUNT #:  
 NAME:  
 ADDRESS:  
 CITY, STATE, ZIP  
 TELEPHONE #:

DATE COLLECTED      TIME       AM      TOTAL VOL/HRS.       Fasting  
 :       PM      \_\_\_\_\_ ML \_\_\_\_\_ HR       Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

ADDIT'L PHYS.: Dr. \_\_\_\_\_ NPI/UPIN \_\_\_\_\_  
 NON-PHYSICIAN PROVIDER:      NAME      I.D.#

Fax Results to: (   ) \_\_\_\_\_

Send Client # OR NAME: \_\_\_\_\_  
 Duplicate ADDRESS: \_\_\_\_\_

**Medicare Limited Coverage Tests**      @ = May not be covered for the reported diagnosis.  
 F = Has prescribed frequency rules for coverage.  
 & = A test or service performed with research/experimental kit.  
 B = Has both diagnosis and frequency-related coverage limitations.

**Provide signed ABN when necessary**

**ICD Codes (enter all that apply)**

\_\_\_\_\_

Note: Quest uses an online system for requisitions. This form is for illustrative purposes.



SPECIMEN KEY ON BACK

FOLD HERE

SPECIMEN KEY ON BACK

FOLD HERE

CONSULT THE SPECIMEN COLLECTION GUIDE FOR SPECIAL INSTRUCTIONS

PROVIDER: \_\_\_\_\_

Fax Results to: ( ) \_\_\_\_\_

Send Client # OR NAME: \_\_\_\_\_

Duplicate ADDRESS: \_\_\_\_\_

Report to: CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

tests **B** = Has both diagnosis and frequency-related coverage limitations. **necessary**

**ICD Codes (enter all that apply)**


**PANEL COMPONENTS ON BACK**

**ORGAN / DISEASE PANELS**

- 34392  Electrolyte Panel S
- 10256  Hepatic Function Panel S
- 10165  Basic Metabolic Panel w/eGFR S
- 10231  Comp Metabolic Panel w/eGFR S
- B** 7600  Lipid Panel (Fasting Specimen) S
- B** 14852  Lipid Panel w/Reflex d-LDL S
- 20210  Obstetric Panel w/Reflex Y,L,S
- @** 10306  Hepatitis Panel, Acute w/Reflex S
- 10314  Renal Functional Panel w/eGFR S

**HEMATOLOGY**

- @** 510  Hemoglobin L
- @** 509  Hematocrit L
- @** 1759  CBC (Hgb, Hct, RBC, WBC, Plt) L
- @** 6399  CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff) L
- B** 8847  PT with INR B
- @** 763  PTT, Activated B

**OTHER TESTS**

- 7788  ABO Group & Rh Type Y
- @** 237  AFP Tumor Marker S
- 223  Albumin S
- 234  Alkaline Phosphatase S
- 823  ALT S
- 243  Amylase S
- 249  ANA w/Reflex Titer S
- 795  Antibody Scr, RBC w/Reflex ID Y
- 822  AST S
- 285  Bilirubin, Direct S
- 287  Bilirubin, Total S

- 4420  C-Reactive Protein CRP S
- @** 29493  CA 27.29 S
- @** 29256  CA 125 S
- 303  Calcium S
- 10124  Cardio CRP S
- 11173  CCP Ab IgG S
- @** 978  CEA S
- B** 334  Cholesterol, Total S
- 374  CK, Total S
- 375  Creatinine w/eGFR S
- 402  DHEA Sulfate, Immunoassay S
- B** 8293  Direct LDL S
- 4021  Estradiol S
- @** 457  Ferritin S
- 466  Folic Acid S
- 470  FSH S
- @** 482  GGT S
- 8477  Glucose, Gest. Scr. GY
- B** 484  Glucose, Plasma GY
- B** 483  Glucose, Serum S
- 14839  H. pylori Urea Breath Test HB
- 8435  hCG, Serum, Qual S
- B** 8396  hCG, Serum, Quant S
- B** 496  Hemoglobin A1c L
- B** 16802  Hemoglobin A1c w/eAg L
- 499  Hep B Surface Ab Qual S
- F** 498  Hep B Surface Ag w/Reflex Confirm S
- 8472  Hep C Virus Ab S
- B** 19728  HIV-1/HIV-2 Scr w/Reflexes S
- 31789  Homocysteine, Cardiovascular S
- 561  Insulin S
- 549  Immunofixation (IFE) S
- @** 7573  Iron (Total), IBC, % Sat S

- @** 571  Iron, Total S
- 593  LDH S
- @** 599  Lead (B) TN
- 615  LH S
- 606  Lipase S
- 6646  Lyme Disease Ab w/Reflex to Blot (IgG, IgM) S
- 622  Magnesium S
- 6517  Microalbumin, Random Urine w/Creat S
- Fecal Globin, Feces - FIT, InSure<sup>®</sup>
- 11290  DX **F** 11293  MCR Scr
- 718  Phosphorus S
- 733  Potassium S
- 745  Progesterone S
- 746  Prolactin S
- B** 5363  PSA, Total S
- 793  Reticulocyte Count, Automated L
- 4418  Rheumatoid Factor S
- F** 799  RPR (Monitoring) w/Reflex Titer S
- F** 36126  RPR (DX) w/Reflex Confirm S
- 802  Rubella IgG S
- 809  Sed Rate By Mod West L
- 15983  Testosterone, Total, LC/MS/MS SR
- 873  Testosterone, Total, Male SR
- 5081  Thyroid Peroxidase Antibodies (TPO) S
- B** 896  Triglycerides S
- B** 899  TSH S
- B** 36127  TSH w/Reflex T-4, Free S
- 34429  T-3, Free S
- 859  T-3, Total S
- B** 861  T-3 Uptake S
- B** 867  T-4 (Thyroxine), Total S
- B** 866  T-4 (Thyroxine), Free S

- 6448  UA, Dipstick Only U
- 7909  UA, Dipstick w/Reflex Microscopic U
- 5463  UA, Complete (Dipstick & Microscopic) U
- 3020  UA, Complete, w/Reflex Culture U
- 294  Urea Nitrogen (BUN) S
- 905  Uric Acid S
- 916  Valproic Acid SR
- 4439  Varicella-Zoster Virus Ab (IgG) S
- 7065  Vitamin B12/Folic Acid S
- 927  Vitamin B12 S
- B** 17306  Vitamin D (QuestAssure D25-OH) D2, D3, LC/MS/MS SR

**MICROBIOLOGY**

- Source (Required) \_\_\_\_\_
- 4550  Culture, Aerobic Bacteria\*
  - 4446  Culture, Aerobic & Anaerobic\*
  - 4485  Culture, Group A Strep\*
  - 5617  Culture, Group B Strep\*
  - 4558  Culture, Genital\*
  - 394  Culture, Throat\*
  - @** 395  Culture, Urine, Routine\*(Inc. Indwelling Cath.)

**Amplified Specimen Type (Aptima)**

Endocervical  Urethral  Urine

**F** 11363  Chlamydia & N. gonorrhoeae RNA, TMA

- Stool Pathogens** (Campy, Salm/Shigella, (Campy, Salm/Shigella, Shiga toxins w/Reflex)\*)
- 10108  Culture, Stool, Shiga toxins w/Reflex\*
  - 34838  H. pylori Ag, EIA Stool
  - 681  O & P w/Permanent Stain

\* Additional charge for ID and Susceptibilities

ADDITIONAL TESTS: (INCLUDE COMPLETE TEST NAME AND ORDER CODE) Reflex tests are performed at an additional charge.

Quest, Quest Diagnostics, the associated logo and all associated Quest Diagnostics marks are the trademarks of Quest Diagnostics. Copyright © 2012 Quest Diagnostics Incorporated. All rights reserved. www.questdiagnostics.com. All other marks - ® and ™ - are the property of their respective owner. 01203540-QWG-3PT. Revised 11/13.

COMMENTS, CLINICAL INFORMATION: \_\_\_\_\_

TOTAL TESTS ORDERED

Physician Signature (Required for PA, NY, NJ & WV) \_\_\_\_\_

**For any patient of any payor (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient.**





# Specimen Labels

- Always label specimens at the time of collection.
- Use a **minimum of two patient identifiers on every specimen** submitted for testing along with Time and Date of Collection. Patient identifiers include Patient Full Legal Name (First and Last) AND Patient Date of Birth (DOB).
- The IDPH Laboratories do not provide labels for the vial. We advise to use the label on the tube (if applicable), chart labels or blank address labels. Other labs may provide labels – check with them to confirm
- Ensure specimen is properly sealed. Specimen may be sealed with parafilm or tape to ensure no leakage during shipment.

# Specimen Label - Example



## Swabbing Steps 4-5

4. Perform Hand hygiene
5. Use gown, procedure mask or fit tested N95, face shield or goggles, gloves per facility guidance and risk assessment.



Face shield or goggles

N95 or higher respirator  
When respirators are not available, use the best available alternative, like a facemask.



Isolation gown



# Using PPE

## Remember:

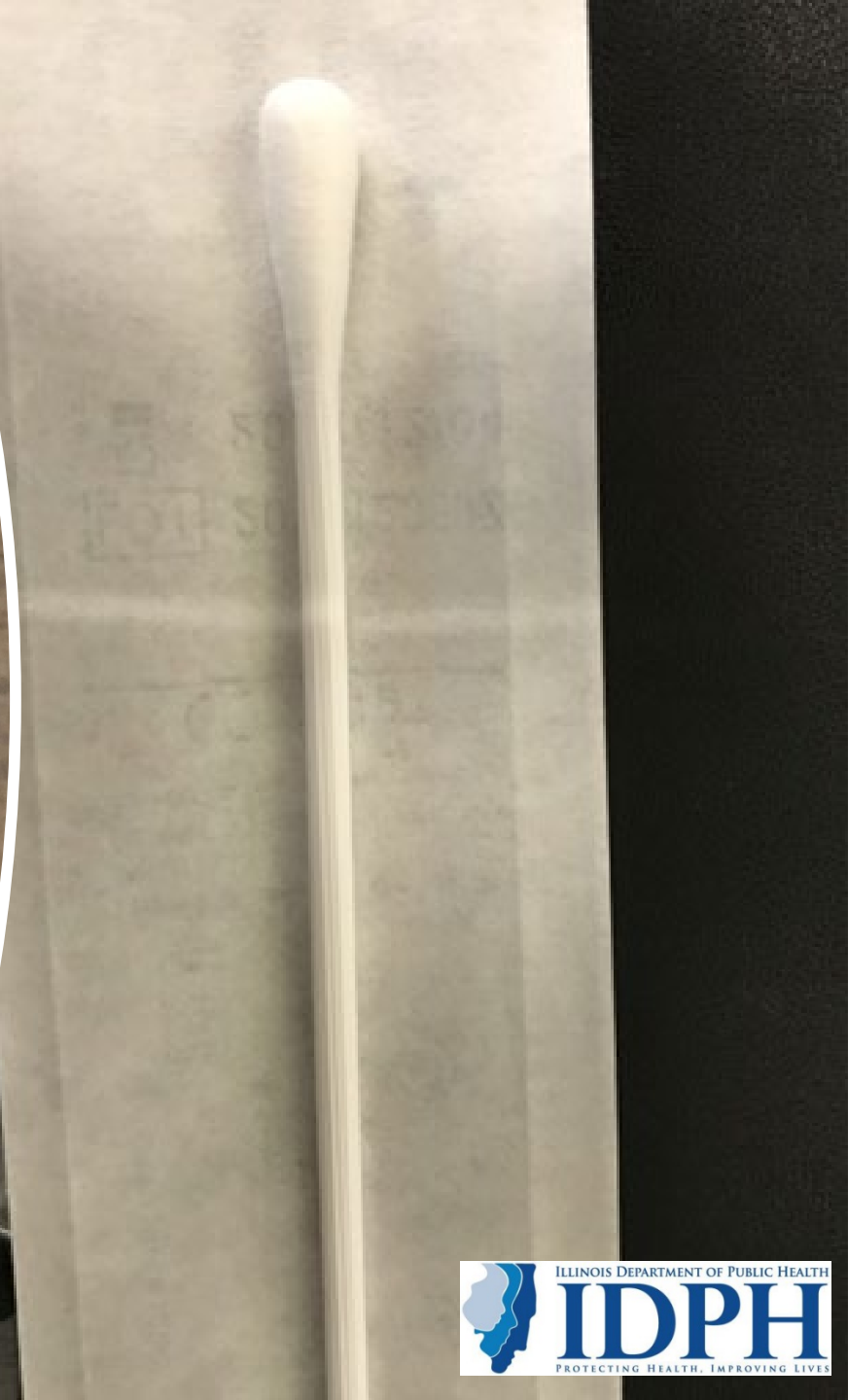
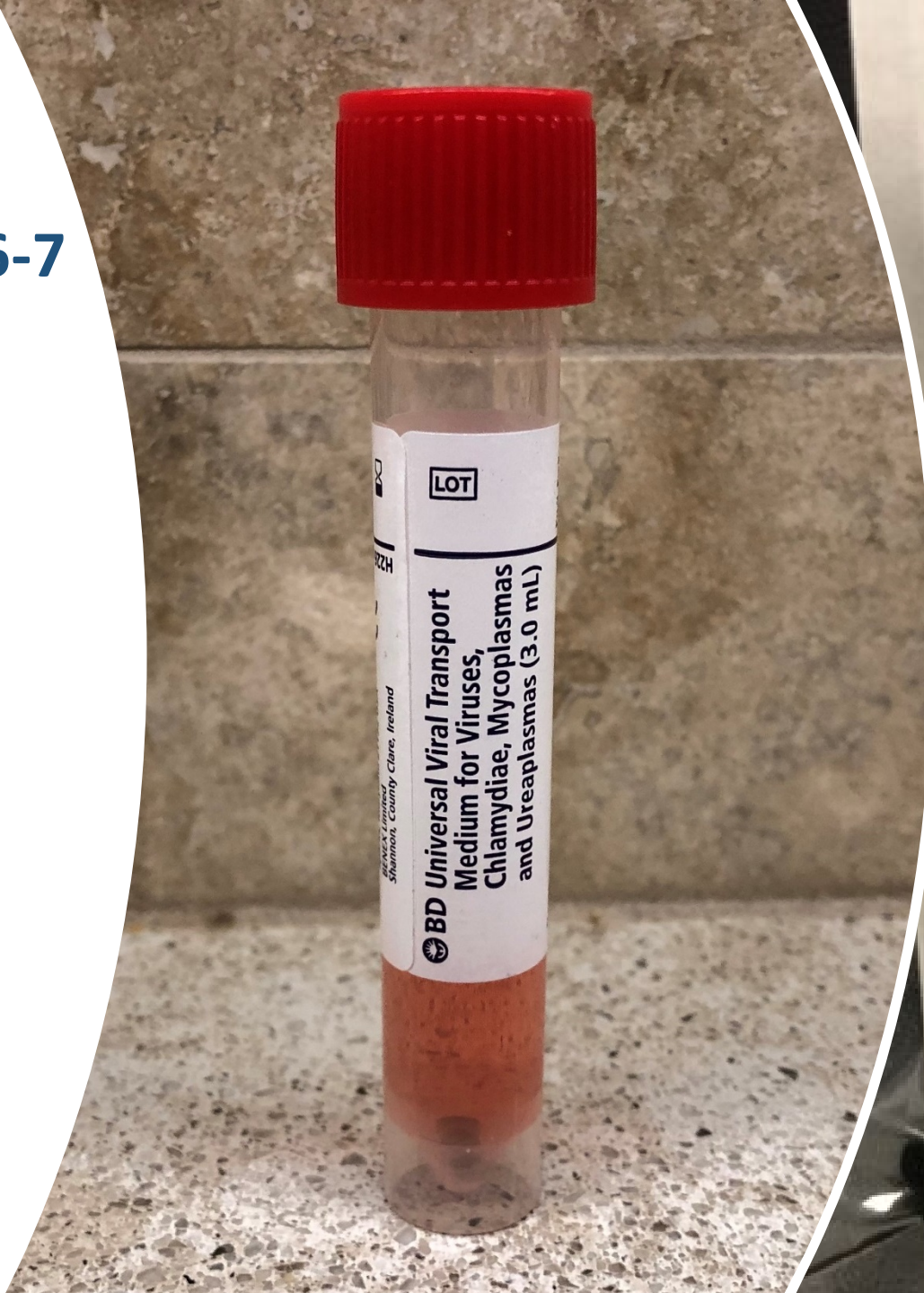
- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.



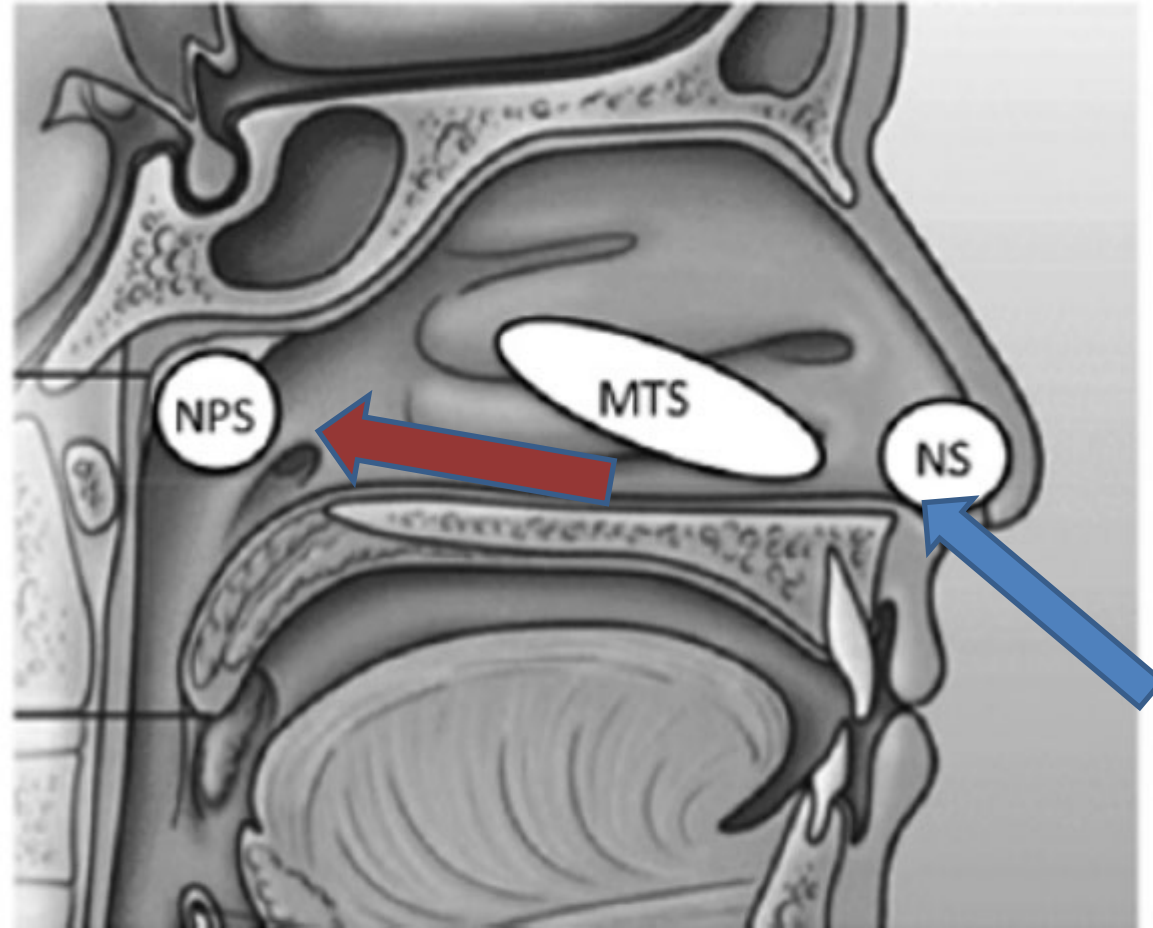
## Swabbing Steps 6-7

6. Twist to remove the cap from the viral transport media tube

7. Remove the swab and handle carefully to prevent touching the sterile end of the swab

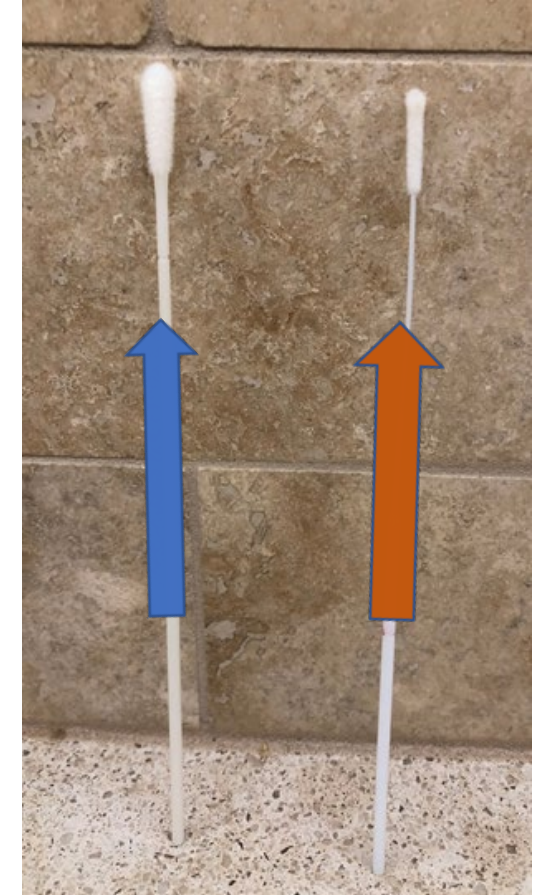


# Step 8: Which Swab?



**Sampling Locations:** NPS, Nasopharyngeal swab; MTS, midturbinate swab; NS, nasal swab. (From Frazee et al., 2018)

NS/Anterior Nares    Nasopharyngeal





# Anterior Nares Swab

Collection instructions: Use a single foam swab for collecting specimens from both nares of a symptomatic patient. Insert foam

Swab into 1 nostril straight back (not upwards).

Once the swab is in place, rotate it in a circular motion 2 times and keep it in place for 15 seconds.

Repeat this step for the second nostril using the same swab. Remove foam swab and insert the swab into an acceptable viral transport medium



# Nasopharyngeal Swab

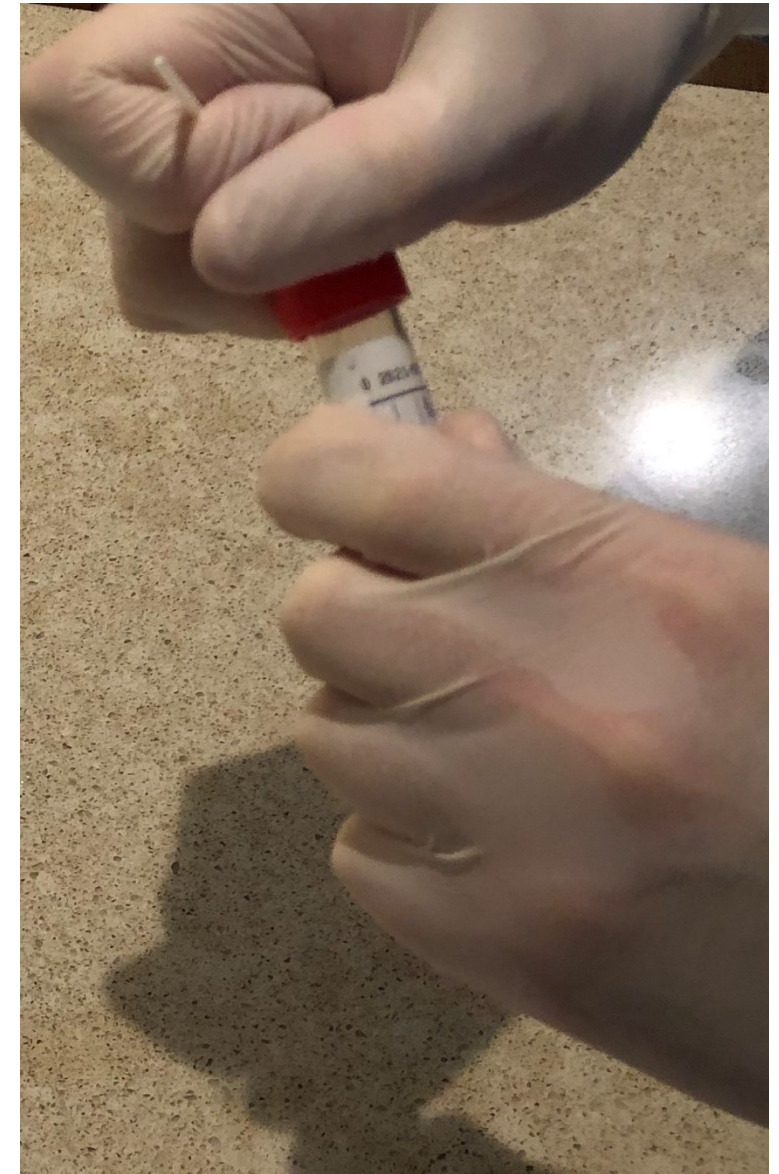
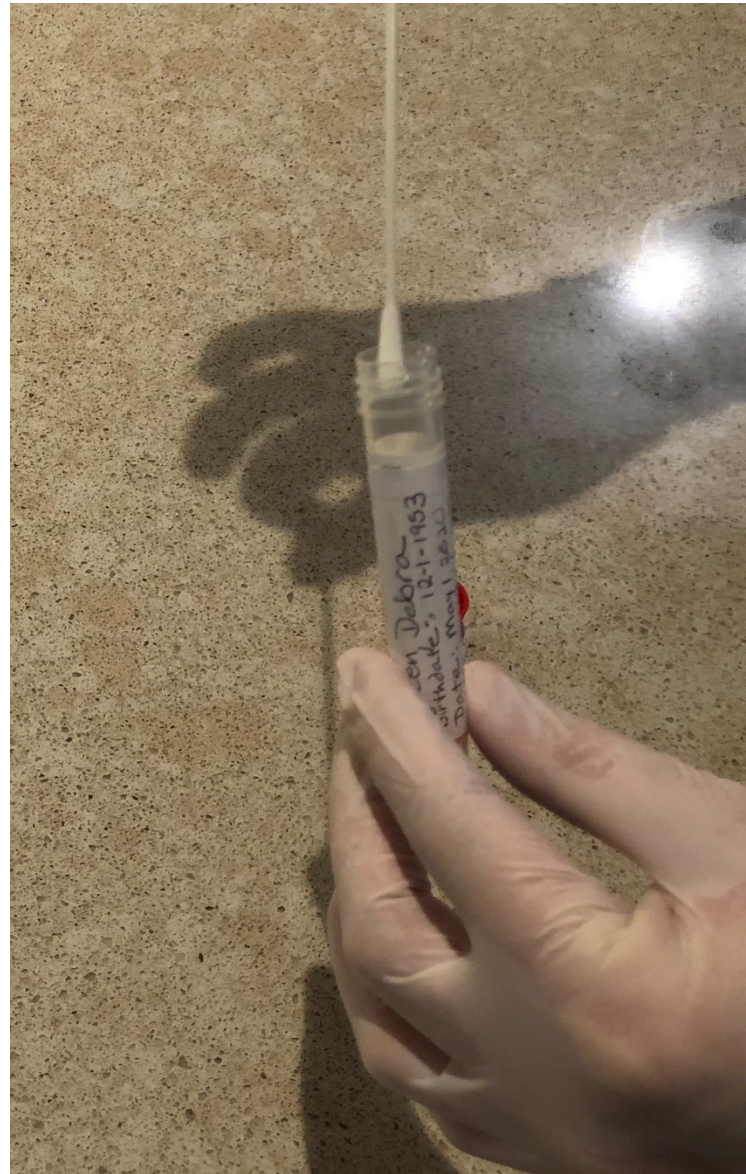


<https://www.youtube.com/watch?v=fOkCVyS8BnQ&feature=youtu.be>



## Swabbing Steps 9-12

9. Place the swab in the transport media tube
10. Ensure that the swab tip is in the viral transport media
11. Bend/cut/snap the applicator stick as appropriate such that the cap can be secured
12. Secure the cap on the transport tube tightly to prevent leakage





# Swabbing Steps 13-14

13. Double check name, spelling, and date of birth and place in transport/storage bag with requisition. Place the requisition in the designated pouch.

14. Please ensure the specimen and requisition form are kept together in one transport bag.

Department of Public Health COVID-19

121011953  
MEDICAID IDENTIFICATION NUMBER

5678  
PATIENT NUMBER

APPLE  
PATIENT NAME (include apartment/suite number)

T BARRINGTON IL 60  
ADDRESS (include apartment/suite number) STATE ZIP CODE

123-1234  
PHONE NUMBER

1202016:00 05/10/2  
DATE TIME COLLECTED SYMPTOM ONSET DATE

TESTING CRITERIA ONLY ONE SAMPLE PER FORM

Arbovirus Panel  
Influenza

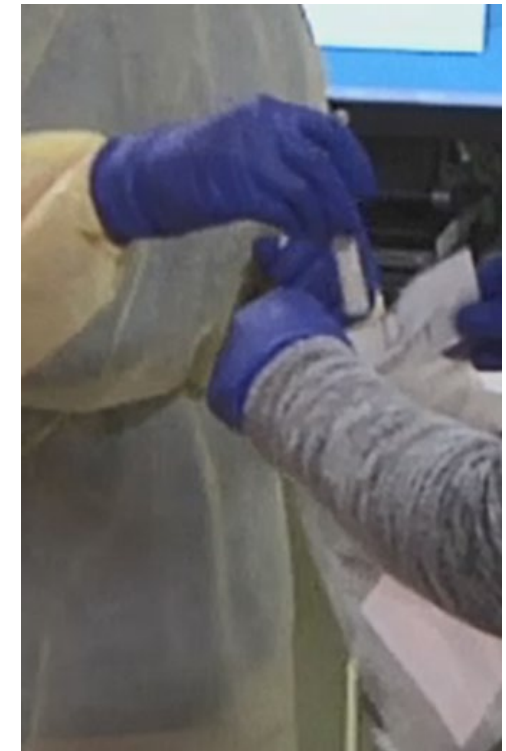
Nasopharyngeal Swab  
Pharyngeal Swab  
Oropharyngeal Swab

Nasal Aspirate  
Nasal Swab  
Sputum

Nasopharyngeal Wash/Aspirate  
Bronchoalveolar Lavage (BAL)  
Lower Respiratory Tract Aspirates

Specimen Number Area Below

Green, Debra  
Birthdate 12-1-1953



# Swabbing Process Step 15

## 15. **Samples require refrigeration!**

Store the specimen at 2-8 degrees C. prior to and during shipment to the laboratory.

Please note that all specimens must be received at the lab within 72 hours of collection.

Use frozen ice packs to maintain temperatures during transit. Do not use wet ice.





# Remove Gloves and Perform Hand Hygiene





# Swabbing Process

## Steps 16-17

16. Remove gloves, perform hand hygiene, put on fresh gloves, sanitize pen and surfaces.
17. Courier or ship specimens to the laboratory quickly.



# Shipping or Using a Courier

- If shipping, be sure to use overnight shipment.
- For Friday shipments, be sure to designate Saturday delivery or UPS won't deliver even if shipped overnight.
- The safest bet is to drive the samples to the lab.
- They must be kept cold and received at the lab within 72 hours of collection or they will be unsatisfactory for testing.