

|                            |                   |
|----------------------------|-------------------|
| <b>Date of Collection:</b> | <b>Sample ID:</b> |
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**Artemis Sample Collection**

Unused sample collection tubes should be stored cold.

The swab used in a rapid antigen test such as BinaxNow can be submitted for sequencing.

Steps:

1. Collect sample and label tube with sample ID (Clinic initials\_date\_sequential number).
  - o Example: for the first sample from Health Hut on July 22, 2021 enter HH\_072221\_1.
2. Complete patient data below.
3. Store the collected sample in a refrigerator (do not freeze) and contact researcher for pickup.

**Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Parish/County of Residence:** \_\_\_\_\_

**Ethnicity/Race(s) — check all that apply**

- White** (German, Irish, Italian, Polish, etc.)
- Hispanic, Latinx, or Spanish** (Mexican or Mexican-American, Puerto Rican, Cuban, etc.)
- Black or African American** (African American, Jamaican, Nigerian, Ethiopian, etc.)
- Asian** (Chinese, Filipino, Asian Indian, Vietnamese, etc.)
- American Indian or Alaska Native** (Navajo Nation, Mayan, Inupiat, Eskimo, etc.)
- Native Hawaiian or other Pacific Islander** (Native Hawaiian, Samoan, Chamorro, Fijian, etc.)
- Other race, ethnicity, or origin**
- Unknown / Do Not Wish to Disclose**

**Are you currently experiencing any of these symptoms?**

- |   |   |
|---|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Fever or chills</b>                             | <input type="checkbox"/> No <input type="checkbox"/> Yes <b>New loss of taste or smell</b>          |
| <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Cough</b>                                       | <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Nausea or vomiting or diarrhea</b>      |
| <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Muscle, body or head aches</b>                  | <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Sore throat, congestion, runny nose</b> |
| <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Shortness of breath or difficulty breathing</b> |   |

**Are you pregnant?**  No  Yes

**Have you previously tested COVID-19 positive?**  No  Yes on \_\_\_\_/\_\_\_\_ (month/year)

**Have you been vaccinated against COVID-19?**

- No
- Yes, I received the Johnson & Johnson (Janssen) vaccine
- Yes, I received the Moderna vaccine
- Yes, I received the Pfizer vaccine

Please provide approximate dates if exact dates are not known.

Dose #1 on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year) Dose #2 on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  
 Booster on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)