

Lab Name

Abbott ID Now Covid-19 Patient Results Log

Test Kit Lot Number: Kit Expiration Date:	Date Kit was Received: Date Kit was Opened:	Quality Control Performed by:
Positive Control Swab Results: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Negative Control Swab Results: <input type="checkbox"/> Neg <input type="checkbox"/> Pos	Procedural QC POS: <input type="checkbox"/> Valid <input type="checkbox"/> Invalid Procedural QC NEG: <input type="checkbox"/> Valid <input type="checkbox"/> Invalid	QC Acceptable? <input type="checkbox"/> OK <input type="checkbox"/> Not OK
Document Corrective Action here:		Supervisor's Initials: Date of Review:

Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Name:	Medical Record Number:	Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> *POSITIVE*	Procedure Control: <input type="checkbox"/> Valid <input type="checkbox"/> INVALID	Tested by:
If POSITIVE, Provider or Nurse Name Notified:		Time of Notification:	If POSITIVE, result reported to State Public Health Laboratory/Epidemiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Tape Analyzer Print-outs behind this sheet.