COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES

Division of Consolidated Laboratory Services

600 N 5th St. Richmond, Va. 23219

Clinical Microbiology/Virology Request Form

Patient Information (Please Print)

Name JOHNSON (Last) BETTY (First) M. (Middle Initial) DOB MM / DD / YYYY (mm dd yyyy) Age 55 ○M XF

Pt Address PATIENT ADDRESS City_____, State_____ Zip Code _____

City/County of Residence_____

Medical Record/Chart/Accession# UNIQUE PATIENT IDENTIFIER FOR YOUR FACILITY HERE… Patient ID OR HERE

Marital Status: ○ single ○ married ○ separated ○ divorced ○ widowed ○ unknown

Race: X Black ○ White ○ Asian ○ AI/AN ○NH/PI ○ Other _____ **Ethnicity:** X Hispanic/Latino ○ Not-Hispanic/Latino

(check all that apply)

Submitter Information

Submitter Code # _____ Site code_____ FIPS code_____

Send Report to:

Submitter THE NAME OF YOUR FACILITY MUST MATCH NAME USED BY DCLS Submitter Phone # XXX-XXX-XXXX

Submitter Address ADDRESS OF YOUR FACILITY AS IN DATABASE City _____, State _____ Zip code_____

Attending Clinician DOC

Attending Clinician Phone # FACILITY - PHONE - NUM

District or PH Contact Phone # _____-_____-_____

Site Type

○ STD	○ ATS	○ DCJ	○FP	○ GYN	X Priv Phys
○ OB/prenatal care	○ AHC	○ Field	○ IMM	○ Job Corp	○ Peds
○ TB	○ GMC	○ CHC	○ DTC	○ Refugee	○ SOI
X Hospital	○ OCME	○ Student HC		○ Other _____	

Patient Medical History

Disease suspected/Diagnosed INFLUENZA

Signs/Symptoms

□ Asymptomatic X Fever □ Respiratory □ Bloody sputum

X Cough □ Productive cough □ Rash □ Vomiting

□ Diarrhea □ Stool + Blood □ Stool + Mucous □ Abdominal Pain

□ Apnea □ SIDS □ Sudden Unexplained Death

Administered_____

X Other SORE THROAT

Recent Exposure (if applicable) □ Birds □ Ticks □ Mosquitoes

□ Other _____

Date of Onset: MM / DD/ YYYY (mm dd yyyy)

Deceased Date: _____/_____/_____ (mm dd yyyy)

Vaccine

(Please specify)

Vaccine Administration Date_____/_____/_____ (mm dd yyyy)

Antibiotics/Anti-Viral Used _____

(Please specify)

Antibiotics/Antiviral Start Date _____/_____/_____ (mm dd yyyy)

Special Information for Laboratorians

Outbreak Related □ no □ yes Outbreak Number: RES989FLUSENTINEL16

Role of Patient (ex. food-handler, patron):_____

□ Other Information_____

***Complete information on back**

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES

Clinical Microbiology/Virology Request Form

Test Request: **Patient Name/Identifier** JOHNSON, BETTY M. **Date of Birth** MM/ DD/ YYYY

Enteric Screen/ Enteric Pathogens

Date Specimen Collected ___/___/___ (mm dd yyyy)

Stool preserved in Cary-Blair Transport (Ship Room Temp)
□ Salmonella/Shigella/E. coli 0157/Campylobacter
□ Shiga Toxin □ Yersinia □ Vibrio
□ Other_____

Unpreserved Stool (Ship Cold Pack)
□ Norovirus
□ Other_____

Follow-up specimen? □ yes □ no If yes, what organism_____

Parasites: Intestinal and Blood-borne

Date(s) Collected (1) ___/___/___; (2) ___/___/___ (mm dd yyyy)

□ Ova and Parasite □ Pinworm
□ Cyclospora □ Blood Parasites
□ Giardia/Cryptosporidium FA
□ Other_____

Submitted in: (Room Temp)
□ 10% Formalin □ PVA □ EDTA Blood
□ Smears/slides □ Other_____

Unpreserved Stool (Cold Pack) Upon Request
□ Cyclospora □ Other_____
□ Cryptosporidium

□ Refugee Country visited outside US_____

Pertussis

Date Specimen Collected ___/___/___ (mm dd yyyy)

B. pertussis: □ Culture □ PCR B. parapertussis: □ Culture
□ Other_____

Source:
□ Nasopharyngeal Swabs (Right and Left Nares)
□ Other_____

Clinical / Specimen Culture (Including OCME):

□ **Bacterial** □ **Fungal** x **Viral** □ **Toxin**

Date Specimen Collected MM/ DD/ YYYY (mm dd yyyy) 14 15

Source: □ Blood □ Urine □ Sputum □ Stool x Swab (site) NP 16 □ Wound/Lesion (Site)_____ □ Respiratory _____

□ Tissue (type) _____ □ Body Fluid (type)_____ □ Other _____

Organism/Toxin Suspected: INFLUENZA **Submitted on** (type media) _____

Reference Culture / Isolate:

□ **Bacterial** □ **Enteric** □ **Fungal** □ **Viral** □ **PFGE** 17

Date Specimen Collected ___/___/___ (mm dd yyyy) Test Requested: _____

Source: □ Blood □ CSF □ Urine □ Sputum □ Stool □ Swab (site)_____ □ Wound/Lesion(Site)_____ □ Respiratory_____

□ Tissue (type) _____ □ Body Fluid (type) _____ □ Other_____

Organism Suspected: _____ **Submitted on** (type of media) _____

Specimen or Reference Culture for TB or other AFB (*Mycobacterium* spp.)

Date Specimen Collected: (1) ___/___/___ (2) ___/___/___ (3) ___/___/___ (mm dd yyyy)

Specimen Source: □ Spontaneous Sputum □ Induced Sputum □ Bronchial Wash/BAL □ Pleural Fluid □ CSF □ Peritoneal Fluid
□ Lymph Node □ Blood □ Urine □ Stool □ Tissue (type) _____ □ Other_____

Sputum Type: □ Raw □ Partially processed □ Processed □ Postmortem

Organism Suspected: _____ **Submitted on** (type media) _____

Additional testing requested: □ 2nd line drugs _____

Information to be included on final report as per request of submitter:

DCLS

INSTRUCTIONS FOR FILLING OUT LAB FORM FOR SENTINEL SURVEILLANCE OF SUSPECTED INFLUENZA CASES

FOR SENTINEL FLU SURVEILLANCE, ONLY THE FIELDS MARKED IN **RED**
ARE REQUIRED. PLEASE WRITE CLEARLY.

1. PATIENT NAME, LAST NAME FIRST. THIS MUST EXACTLY MATCH THE NAME AS WRITTEN ON THE LAB SPECIMEN TUBE

2. PATIENT AGE / DOB MUST EXACTLY MATCH THE DATA AS WRITTEN ON THE LAB SPECIMEN TUBE

3. PLEASE INDICATE PATIENT GENDER

4. PLEASE FILL IN PATIENT'S ADDRESS OF RESIDENCE

5. YOUR FACILITY'S ID NUMBER FOR THE PATIENT; ONLY ONE IS NEEDED

6. PLEASE INDICATE PATIENT'S RACE / ETHNICITY

7. YOUR FACILITY'S NAME AND CONTACT DATA MUST MATCH THOSE GIVEN TO THE STATE LABORATORY FOR YOUR SITE. IF UNSURE, PLEASE CHECK WITH YOUR DISTRICT EPIDEMIOLOGIST.

8. NAME AND PHONE NUMBER OF RESPONSIBLE PHYSICIAN OR CLINICIAN

9. PLEASE INDICATE: SITE IS *EITHER* A PRIVATE PRACTICE **OR** HOSPITAL / ER / URGENT CARE CENTER

10. ALWAYS, INDICATE *FLU* OR *INFLUENZA*

11. PATIENT **MUST** HAVE FEVER plus COUGH **and / or** SORE THROAT IN ORDER TO MEET SURVEILLANCE CRITERIA; FEVER **MUST** BE MINIMUM OF 100° F

12. DATE OF ONSET: PLEASE INDICATE WHEN SYMPTOMS BEGAN

13. PLEASE DOCUMENT OUTBREAK ID: **RES989FLUSENTINEL16**

14. PLEASE DOCUMENT DATE SPECIMEN WAS COLLECTED

15. PLEASE INDICATE VIRAL SPECIMEN

16. PLEASE INDICATE NP SWAB

17. ORGANISM SUSPECTED = INFLUENZA OR FLU