

	VIRAL IDENTIFICATION PUBLIC HEALTH LABORATORY TEST REQUEST	FOR LAB USE ONLY
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DATE * (MM/DD/YYYY): *** Required information**

1. PATIENT INFORMATION			
PATIENT LAST NAME *:		PATIENT FIRST NAME *:	
<input style="width:400px;" type="text"/>		<input style="width:200px;" type="text"/>	
DATE OF BIRTH * (MM/DD/YYYY):	Sex *:	PATIENT ID#/MEDICAL RECORD#:	
<input style="width:150px;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input style="width:150px;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width:250px;" type="text"/>	<input style="width:150px;" type="text"/>	<input style="width:50px;" type="text"/>	<input style="width:50px;" type="text"/>
TELEPHONE:	Ext.:	PHYSICIAN: (if other than submitter)	Pager/Cell:
<input style="width:100px;" type="text"/>	<input style="width:50px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>

2. SUBMITTER INFORMATION			
NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc. *:		PROVIDER ID#:	
<input style="width:400px;" type="text"/>		<input style="width:150px;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME *:		FIRST NAME *:	
<input style="width:400px;" type="text"/>		<input style="width:150px;" type="text"/>	
ADDRESS *:			
<input style="width:400px;" type="text"/>			
CITY *:		STATE *:	ZIP *:
<input style="width:150px;" type="text"/>		<input style="width:100px;" type="text"/>	<input style="width:50px;" type="text"/>
TELEPHONE *:	Ext.:	Pager/Cell *:	Fax:
<input style="width:100px;" type="text"/>	<input style="width:50px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:50px;" type="text"/>
		EMAIL:	
		<input style="width:150px;" type="text"/>	

3. SPECIMEN INFORMATION			
DATE OF COLLECTION * (MM/DD/YYYY):		TIME OF COLLECTION * [00:00]:	
<input style="width:150px;" type="text"/>		<input type="checkbox"/> <input type="checkbox"/> AM PM (where applicable)	
Reason for submission *	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BOI <input type="checkbox"/> BTBC <input type="checkbox"/> BSTD <input type="checkbox"/> OTHER (specify):		DOHMH EVENT CODE:
B. DOHMH contact	Last Name:		First Name:
	<input style="width:150px;" type="text"/>		<input style="width:100px;" type="text"/>
Is this submission for referral? *	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input checked="" type="radio"/> NYS <input type="radio"/> CDC <input type="radio"/> OTHER (specify):		
Specimen *	<input checked="" type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Nasal aspirate <input type="checkbox"/> Nasal wash <input type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Buccal swab <input type="checkbox"/> Stool <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Vesicle/other lesion (specify type): <input type="checkbox"/> Isolate (Cell Line): <input type="checkbox"/> Other (specify type):		
Additional testing information	Date of symptom onset (MM/DD/YYYY):		
	<input style="width:150px;" type="text"/>		
	Exposure/travel history:		
	<input style="width:150px;" type="text"/>		
Additional comments:	<input style="width:400px;" type="text"/>		
Clinical syndrome:	<input style="width:400px;" type="text"/>		

4. TEST(S) REQUESTED *	
<input type="checkbox"/> Influenza A and B Direct Antigen Detection	<input type="checkbox"/> Rotavirus Direct Antigen Detection
<input type="checkbox"/> Influenza A and B real-time RT-PCR	<input type="checkbox"/> RSV Direct Antigen Detection
<input type="checkbox"/> Influenza A Subtyping (H1/H3) real-time RT-PCR	<input type="checkbox"/> Virus Isolation/Detection
<input type="checkbox"/> Influenza A/H5 real-time RT-PCR (DOHMH Request ONLY) ¹	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Smallpox Rule-Out Assays (DOHMH Request ONLY) ¹	<input type="checkbox"/> Other (specify):

LTR_DVI02F_109

¹Call (212) 788-9830