[1] 1. Last Name | First Name | MI

2. Patient Number

3. Address

Zip Code

4. Date of Birth

Month | Day | Year

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Pacific Islander ☐ 6. Unknown

6. Hispanic or Latino Origin? ☐ 1. Yes ☐ 2. No ☐ 3. Unknown

7. Sex ☐ 1. Male ☐ 2. Female

8. Co. of Residence

9. Medicaid Client ☐ Yes ☐ No
If yes, enter #

DO NOT WRITE IN THIS SPACE
LABORATORY NUMBER

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

PLEASE GIVE ALL INFORMATION REQUESTED

VIROLOGY

[2] FEDERAL TAX NO. ______

SEND REPORT TO:

______

______

______ Zip Code: ______

[3] *Contact Name:* ______

Phone: ______

Fax: ______

[4] INFECTIOUS AGENT(S) SUSPECTED OR TEST(S) REQUIRED:
❑ Herpes simplex ❑ Influenza ❑ Viral Culture ❑ Mumps
❑ VZV ❑ CMV ❑ Other ______

[5] SPECIMEN SOURCE	[6] DATE COLLECTED
(a)	
(b)	
(c)	

[7] CLINIC:
_____ Prenatal
(Due Date: ________)
_____ STD
_____ OTHER

[8] ONSET DATE:

[9] Dx Code/ICD-9:

[10] **PATIENT SIGNS AND SYMPTOMS** Patient Expired? ❑ Yes Date: ______

GENITAL
- ❑ Vesicles
- ❑ PID
- ❑ Cervicitis
- ❑ Urethritis
- ❑ Hysterectomy
- ❑ Mucopurulent discharge
- ❑ Atypical Lesion

RASH
- ❑ Macular
- ❑ Papular
- ❑ Vesicular
- ❑ Petechial
- ❑ Focal
- ❑ Hemorrhagic

RESPIRATORY
- ❑ Cough
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Croup
- ❑ Pharyngitis

CNS
- ❑ Seizures
- ❑ Meningitis
- ❑ Encephalitis
- ❑ Nuchal rigidity
- ❑ Paralysis

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Pericarditis
- ❑ Myocarditis
- ❑ Pleurodynia

GASTROINTESTINAL
- ❑ Nausea/vomiting
- ❑ Diarrhea

GENERAL
- ❑ Fever to _____ °
- ❑ Headache
- ❑ Fatigue
- ❑ Sore Throat
- ❑ Jaundice
- ❑ Conjunctivitis

Recent Vaccination History:

Travel History:

Instructions

PURPOSE: Submission of specimens for detection of viral infectious agents by viral culture and/or molecular diagnostics.

PREPARATION: Clearly label each specimen primary container with the patient's first and last name, either date of birth, patient number or other unique identifier, specimen source and collection date. Specimens without names or incorrectly labeled specimens will be deemed unsatisfactory for testing. Submit no more than three specimens per patient with each form. For additional information, see "SCOPE, A Guide to Services" on our website at http://slph.ncpublichealth.com or contact the Virology/Serology Unit at (919)733-7544.

PREPARATION OF FORM: Please print legibly or use a preprinted label. To avoid delays in testing, fill out all items in Sections 1 through 10 of the submission form. Enclose submission form in a plastic bag to prevent contamination due to possible leakage.

SHIPMENT: Keep properly identified specimens cold BUT NOT FROZEN (cold packs and leak-proof Styrofoam container) and deliver to the Laboratory within 48 hours of collection. Specimens for CMV, RSV or VZV culture should be refrigerated immediately after collection and delivered to the Laboratory within 24 hours. Additional specimen collection and transport kits are available through the NCSLPH online supply ordering system on our website at http://slph.ncpublichealth.com

DISPOSITION: This form may be destroyed in accordance with Standard 5, Patient Clinical Records, of the Records Disposition Schedule published by the N.C. Division of Archives and History.

FOR LABORATORY USE ONLY

Unsatisfactory Specimen:
- ❑ No name on specimen
- ❑ Name on specimen/form do not match
- ❑ Specimen broken/leaked
- ❑ Collected in incorrect transport media
- ❑ Other ______

TEMPERATURE ON ARRIVAL: ❑ FROZEN ❑ COLD ❑ AMBIENT **DATE RECEIVED**

Comments:
- ❑ Four or more days between collection and receipt of specimen
- ❑ Specimen broken or leaked in transit
- ❑ Specimen received ambient
- ❑ Other ______

Results telephoned to ______

date ______

by ______

INTERPRETATION:
- ❑ Negative: No virus detected.
- ❑ Virus detected using molecular assay.
- ❑ Virus detected using DFA method.
- ❑ Viral-like agent detected. Further testing in process.
- ❑ Positive virus identified as: