VIROLOGY

State Form 35212 (R6/9-09)
CLIA Certified Laboratory #15D0662599

Indiana State Department of Health Laboratories
550 W. 16th Street, Suite B
Indianapolis, IN 46202
(317) 921-5500

Use a separate form for each specimen. Complete form entirely. Specimens without a name will not be analyzed.

Section 1. Patient Demographics

Last Name ______ First Name ______ MI ___ Date of Birth ___/___/______

Number & Street Address ______ City ______ State ___ ZIP Code ______

County of Residence ______ Telephone Number ___-___-______

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Multiracial
- ☐ Other
- ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Sex: ☐ Male ☐ Female ☐ Unknown

Name of ☐ Employer ☐ School ☐ Care Facility ☐ Institution ______ Facility Telephone Number ___-___-______ Occupation ______

Institution Resident ? ☐ Yes ☐ No **Institution Type** ☐ Prison ☐ Nursing Home ☐ Other *(specify)* ______

Hospitalized? ☐ Yes ☐ No **Location** ______ Date Hospitalized ___/___/______

Deceased? ☐ Yes ☐ No **Date of Death** ___/___/______

Section 2. Clinical Information

Date of Collection ___/___/______ **Date of Illness Onset** ___/___/______

Specimen Information:
- ☐ Swab *(Anatomical Source)* ______
- ☐ Tissue *(Anatomical Source)* ______
- ☐ Stool
- ☐ Fluid *(Anatomical Source)* ______
- ☐ Isolate *(Anatomical Source)* ______
- ☐ Other: ______

Clinical Diagnosis ______

State of Illness ☐ **Asymptomatic** ☐ **Symptomatic** ***(If patient is symptomatic, please check all signs/symptoms that apply)***

General Symptoms	CNS	Rash	Respiratory	Gastrointestinal	Miscellaneous
☐ Fever ___ °F	☐ Encephalitis	☐ Maculopapular	☐ Upper Resp. Inf.	☐ Vomiting	☐ Parotitis
☐ Headache	☐ Meningitis	☐ Papular	☐ Lower Resp. Inf.	☐ Diarrhea	
☐ Sore Throat	**Ocular**	☐ Hemorrhagic	☐ Pneumonia	**Cardiovascular**	
☐ Cough	☐ Conjunctivitis	☐ Vesicular	☐ ARDS	☐ Heart Inflammation	
	☐ Photophobia	☐ Petechial			

Other Symptoms ***(please specify)*** ______

Pregnant ? ☐ Yes ☐ No **Immunocompromised?** ☐ Yes ☐ No

Section 3. Virus Suspected

- ☐ **Adenovirus**
- ☐ **Influenza**
- ☐ **Parainfluenza**
- ☐ **Respiratory Syncytial Virus**
- ☐ **Enterovirus**
- ☐ **Measles**
- ☐ **Mumps**
- ☐ **Varicella**
- ☐ **Herpes Simplex**
- ☐ **Community-Acquired Pneumonia**
- ☐ **Other** ______

Section 4. ISDH Lab Use

For ISDH Lab. Use ONLY

___/___/______
Date Received

Place Label here

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Place ISDH Lab Label Here

Section 5. Influenza Submission Information

______________________ ______________________ ___ ___/___/_____
Last Name **First Name** **MI** **Date of Birth**

Influenza Rapid Test: ☐ Positive ☐ Negative ☐ Not Performed **If positive:** ☐ Type A ☐ Type B ☐ Type A/B ☐ Not Typed

______________________ ___/___/_____ ___/___/_____ ☐ None
Seasonal influenza vaccine type given: **Date 1st Dose** **Date 2nd Dose**

______________________ ___/___/_____ ___/___/_____ ☐ None
Pandemic influenza vaccine type given: **Date 1st Dose** **Date 2nd Dose**

Patient Received/Receiving Antivirals? ☐ Yes ☐ No **Date Administered:** ___/___/_____

Which antiviral prescribed?______________________

Patient Contact with ***(check all that apply):*** ☐ Respiratory Disease Outbreak ☐ Ill Person ☐ Birds ☐ Animals

Section 6. Travel History

Travel history for the past 60 days:

Traveled to/from: ______________________

___/___/_____ ___/___/_____
Date of Departure **Date of Return**

Section 7. Provider Information

____
Healthcare Provider's Name

____
E-Mail Address

___-___-_____ ___-___-_____ ______________
Telephone Number **Fax Number** **Influenza Sentinel Physician Number**

Section 6. Submitter Information *(Reports Will go ONLY to this Facility)*

____
Submitting Facility Name

____
Number & Street Address

______________________ ____ ________
City **State** **ZIP Code**

___-___-_____ ___-___-_____
Telephone Number **Fax Number**

Collect specimen for virus culture and PCR testing as early as possible in the acute stage of illness. Acceptable specimens may include the following: isolates, NP swabs or throat swabs, stools or rectal swabs, body fluids, lesion swabs or scrapings, biopsy tissue (no preservative), and postmortem tissues (no preservative) depending on the suspected virus. Swabs must be placed in 2-3 mL of viral transport media such as M4, M4-RT, UTM-RT, etc.

Refrigerate specimens for virus culture and PCR testing immediately after collection. Ship specimens for next day delivery using ice packs in a heavily insulated box. Pack specimens to prevent breakage or spillage and to conform to shipping regulations.

Viral recovery may be complicated if specimens are not shipped refrigerated immediately after collection. If immediate shipment, for delivery within 24 hours, is not possible, refrigerate or freeze specimens at -70° C or below. Do not store at -20° C. Ship frozen specimens on dry ice in a heavily insulated box. Do not ship on Friday, hold for Monday shipping. Specimens should be be received by the ISDH laboratory within 5 days of collection.