Reset Form

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
- ☐ Fever ___.__ °F
- ☐ Headache
- ☐ Sore Throat
- ☐ Cough

CNS
- ☐ Encephalitis
- ☐ Meningitis

Ocular
- ☐ Conjunctivitis
- ☐ Photophobia

Rash
- ☐ Maculopapular
- ☐ Papular
- ☐ Hemorrhagic
- ☐ Vesicular
- ☐ Petechial

Respiratory
- ☐ Upper Resp. Inf.
- ☐ Lower Resp. Inf.
- ☐ Pneumonia
- ☐ ARDS

Gastrointestinal
- ☐ Vomiting
- ☐ Diarrhea

Cardiovascular
- ☐ Heart Inflammation

Miscellaneous
- ☐ Parotitis

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.