



Errin C. Rider, Ph.D., D(ABMM),M(ASCP)CM
Director of Clinical Laboratory Services
CDD Customer Service
Phone: 800-862-1013
FAX: 844-390-6233

Vaccine Preventable Disease (VPD) rev. 06/2023

Patient Information		Submitter Information	
Name (Last, First):		(Your Institution's WSLH Agency Number If Known) 7071416	
Address:		(Your Institution's Name) WEST VIRGINIA OFFICE OF LAB SERVICES	
City:	State:	Zip:	(Your Institution's Address) 167 11TH AVE
Date of Birth:	Gender: M F	(City, State, Zip Code) SOUTH CHARLESTON, WV 25303-1114	
Your Patient ID Number (optional):		Lab Point of Contact: Nicole Haddox	Telephone Number: 304-558-3530
Your Specimen ID Number (required):		<i>WSLH Use Only</i> Study: CDC VPD	<i>WSLH Use Only: Bill To:</i> (WSLH Account # 115520)
Date Collected: _____	Specimen Type: Other _____ <input type="checkbox"/> Combined Throat/NP Swab <input type="checkbox"/> BAL <input type="checkbox"/> Skin Swab <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> CSF (Site: _____) <input type="checkbox"/> Throat Swab <input type="checkbox"/> Scab <input type="checkbox"/> Whole Blood (EDTA) <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Stool-in Cary Blair <input type="checkbox"/> Isolate: <input type="checkbox"/> Nasopharyngeal Aspirate <input type="checkbox"/> Urine (Source _____)		
Date of Symptom Onset: UNKNOWN		Date of Rash Onset:	
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Antibiotic Treatment (if administered prior to specimen collection):			
Vaccination History: Was patient vaccinated? <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If Yes, Date of Last Vaccination: / /			
Vaccine Type: <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Tdap <input type="checkbox"/> PPSV23 <input type="checkbox"/> MPSV4 <input type="checkbox"/> MMRV <input type="checkbox"/> DTap <input type="checkbox"/> PCV13 <input type="checkbox"/> MCV4 <input type="checkbox"/> Hib			
Submitter Lab Results:			
Culture/Identification Result: _____			
PCR:	Result:	Ct:	RP Ct:



**Wisconsin State
Laboratory of Hygiene**

UNIVERSITY OF WISCONSIN-MADISON

2601 Agriculture Dr, Madison, WI 53718

Errin C. Rider, Ph.D., D(ABMM),M(ASCP)CM
Director of Clinical Laboratory Services
CDD Customer Service
Phone: 800-862-1013
FAX: 844-390-6233

Vaccine Preventable Disease (VPD) rev. 06/2023

Test Order:

- | | |
|--|--|
| <input type="checkbox"/> VR01713 Measles virus PCR | <input type="checkbox"/> VR01737 Varicella zoster virus PCR |
| <input type="checkbox"/> VR01733 Measles virus Genotyping | <input type="checkbox"/> VR01736 Varicella zoster virus Genotyping |
| <input type="checkbox"/> VR01725 Rubella virus PCR | <input type="checkbox"/> MP00561 N. meningitidis PCR |
| <input type="checkbox"/> VR01734 Rubella Genotyping | <input type="checkbox"/> MP00563 N. meningitidis Serogrouping |
| <input type="checkbox"/> VR01714 Mumps virus PCR | <input type="checkbox"/> MP00651 H. influenzae PCR |
| <input type="checkbox"/> VR01735 Mumps virus Genotyping | <input type="checkbox"/> MP00653 H. influenzae Serotyping |
| <input type="checkbox"/> VR02889 Rhinovirus/Enterovirus RT-PCR | |

WISCONSIN STATE LABORATORY OF HYGIENE USE ONLY