

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: Christi Clark	Telephone Number: 304-558-3530 x2602
Your Specimen ID Number (required):		<i>WSLH Use Only</i> Study: CDC VPD	<i>WSLH Use Only</i> : Bill To: (WSLH Account #)
Date Collected: _____	Specimen Type:		
Time Collected: _____	<input type="checkbox"/> Other _____ <input type="checkbox"/> Combined Throat/NP Swab <input type="checkbox"/> BAL <input type="checkbox"/> Skin Swab (site: _____) <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> CSF <input type="checkbox"/> Acute Serum <input type="checkbox"/> Throat Swab <input type="checkbox"/> Scab <input type="checkbox"/> Convalescent Serum <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Stool-raw <input type="checkbox"/> Whole Blood (EDTA) <input type="checkbox"/> Nasopharyngeal Aspirate <input type="checkbox"/> Urine <input type="checkbox"/> Isolate: (Source _____)		
Date Shipped: _____			
Date of Symptom Onset:		Date of Rash Onset:	
Antibiotic Treatment (if administered prior to specimen collection):			
Cough Duration (for pertussis specimens only):			
Vaccination History: Was patient vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If Yes, Date of Last Vaccination: / /			
Vaccine Type:	<input type="checkbox"/> MMR	<input type="checkbox"/> Varicella	<input type="checkbox"/> DTap
	<input type="checkbox"/> MMRV	<input type="checkbox"/> Rota	<input type="checkbox"/> Tdap
		<input type="checkbox"/> PCV13	<input type="checkbox"/> MPSV4
		<input type="checkbox"/> PPSV23	<input type="checkbox"/> Hib
		<input type="checkbox"/> MCV4	
Submitter Lab Results:			
Test	Results		
Culture/Identification	_____		
PCR	_____		
Serology IgM	_____		
Serology IgG	_____		
Test Order:			
<input type="checkbox"/> SS02171 Measles IgM Serology	<input type="checkbox"/> SS02275 B. pertussis anti PT IgG Antibody		
<input type="checkbox"/> VR01713 Measles virus PCR	<input type="checkbox"/> MP00315 Bordetella spp. PCR		
<input type="checkbox"/> VR01733 Measles virus Genotyping	<input type="checkbox"/> MP00461 S. pneumoniae PCR		
<input type="checkbox"/> VR01725 Rubella virus PCR	<input type="checkbox"/> MP00463 S. pneumoniae Serotyping		
<input type="checkbox"/> VR01734 Rubella Genotyping	<input type="checkbox"/> MP00561 N. meningitidis PCR		
<input type="checkbox"/> VR01714 Mumps virus PCR	<input type="checkbox"/> MP00563 N. meningitidis Serogrouping		
<input type="checkbox"/> VR01735 Mumps virus Genotyping	<input type="checkbox"/> MP00651 H. influenzae PCR		
<input type="checkbox"/> VR01727 Varicella zoster virus PCR	<input type="checkbox"/> MP00653 H. influenzae Serotyping		
<input type="checkbox"/> VR01736 Varicella zoster virus Genotyping	<input type="checkbox"/> VR01724 Rotavirus PCR		
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