



VIROLOGY

State Form 35212 (R5/7-08)
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. 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

Race: County of Residence Phone Number
 Asian White
 Black or African American Multiracial
 American Indian or Alaska Native Other
 Native Hawaiian or Other Pacific Islander Unknown
Ethnicity:
 Hispanic or Latino Not Hispanic or Latino Unknown
Sex:
 Male Female Unknown

Name of Employer School Care Facility Institution Facility Phone Number Occupation
Institution Resident? No Yes Institution Type Prison Nursing Home Other (specify) _____

Address of Employer/School/Care Facility/Institution

City State ZIP Code

Section 2. Clinical Information

Specimen Information:
 Isolate Swab Stool Fluid Tissue Other: _____
_____/_____/_____
Date of Illness Onset Date of Collection Is Patient Immunocompromised? Yes No Anatomical Site

Clinical Diagnosis

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

General Symptoms <input type="checkbox"/> Fever _____ <input type="checkbox"/> Headache <input type="checkbox"/> Sore Throat <input type="checkbox"/> Cough	CNS <input type="checkbox"/> Encephalitis <input type="checkbox"/> Meningitis Ocular <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Photophobia	Exanthema <input type="checkbox"/> Maculopapular <input type="checkbox"/> Papular <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Vesicular <input type="checkbox"/> Petechial	Respiratory <input type="checkbox"/> Upper Resp. Inf. <input type="checkbox"/> Lower Resp. Inf. <input type="checkbox"/> Pneumonia <input type="checkbox"/> ARDS	Gastrointestinal <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea Cardiovascular <input type="checkbox"/> Heart Inflammation
--	--	--	---	---

Other Symptoms (please specify)

Is this specimen part of a public health investigation? Yes No Unknown

Section 3. Influenza Submission Information

Influenza Authorization Code Influenza Sentinel Physician #
Influenza Rapid Test: Positive Negative Not Performed If positive: Type A Type B Type A/B Not Typed
_____/_____/_____
Vaccination Date Vaccine Type Killed Vaccine Attenuated Vaccine/Flu Mist Number of Doses: 1 2
Patient Received/Receiving Antivirals? Yes No _____
If Yes, Date Administered
Which antiviral prescribed? _____

Patient Contact with (check all that apply): Birds Animals Family Community Resp. Disease Outbreak

Complete Reverse Side

VIROLOGY

State Form State Form 35212 (R5/7-08)

Section 4. Travel History

Travel history for the past 60 days:

Traveled to/from: _____

____ / ____ / ____
Date of Departure

____ / ____ / ____
Date of Return

Section 5. Virus Suspected

- | | |
|---|---|
| <input type="checkbox"/> Adenovirus | <input type="checkbox"/> Norovirus |
| <input type="checkbox"/> Enterovirus | <input type="checkbox"/> Parainfluenza |
| <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Respiratory Syncytial Virus |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Community-Acquired Pneumonia |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ |

Section 6. Submitter Information

Healthcare Provider's Name

E-Mail Address

____ - ____ - ____ ____ - ____ - ____
Phone Number Fax Number

Submitting Facility Name

Number & Street Address

City State ZIP Code

____ - ____ - ____ ____ - ____ - ____
Phone 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, M5 UTM-RT, etc. Use a 7A container, available from the ISDH Container Section, for Norovirus specimens.

Refrigerate specimens for virus culture and PCR testing immediately after collection at 2-8° C. Wrap the labeled specimen container with absorbent material and place in a biohazard specimen bag to prevent breakage or spillage during shipment. Ship specimens within 24 hours in a heavily insulated box with sufficient ice packs to maintain 2-8° C while in transit. Pack specimens to prevent breakage or spillage. Ship the box compliant with DOT and IATA regulations.

Viral recovery may be complicated if specimens are not shipped refrigerated immediately after collection. If shipment and delivery to the ISDH laboratories is not possible within 24 hours after collection, specimens must be frozen at -70° C or below. Do not store at -20° C. Ship frozen specimens on 10 lb. dry ice in a heavily insulated box. Do not ship on Friday, hold in freezer for Monday shipping.

Specimens should be received by the ISDH Laboratory within 5 days of collection.

For ISDH Lab. Use ONLY

Place Label here

____ / ____ / ____
Date Received