

Virus Detection History

New York State Department of Health
 Wadsworth Center, Empire State Plaza
 Virus Reference and Surveillance Laboratory
 P.O. Box 509
 Albany, New York 12201-0509
 Phone (518) 869-4500 Fax (518) 869-6487
 * Please see instructions for shipping address

NYS Lab Number _____

Date Received _____

Please type or print legibly in black ink

Patient

Last Name		First Name		MI	DOB MM / DD / YY		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City/State		Zip Code		County of Residence	

Specimen

Original Material Isolate Cell line _____ Autopsy Biopsy

NYS DOH Outbreak # _____ CDESS Case ID _____ Submitter Lab # _____

DOH Influenza Sentinel Specimen Yes No SARS suspect Yes No Calicivirus testing

Source <input type="checkbox"/> Stool <input type="checkbox"/> NPS <input type="checkbox"/> Genital <input type="checkbox"/> Urine <input type="checkbox"/> CSF <input type="checkbox"/> Blood <input type="checkbox"/> Vesicle <input type="checkbox"/> Other _____	Date Collected MM / DD / YY	Onset Date MM / DD / YY
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Requesting Medical Provider Name and Address _____ **Laboratory PFI** _____

Contact person _____ **Email** _____

Telephone _____ **Fax** _____

Comments

Diagnosis _____	Virus Suspected _____
Diagnosis/Signs/Symptoms (Please check)	
<input type="checkbox"/> Fever Max. temp. _____ Duration _____ Rash <input type="checkbox"/> Maculopapular <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Vesicular <input type="checkbox"/> Other _____ Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> Upper Resp./Rhinitis pharyngitis <input type="checkbox"/> Pneumonia, type _____ <input type="checkbox"/> X-ray _____ <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pleurisy <input type="checkbox"/> Other _____ <input type="checkbox"/> Pregnant Trimester _____ <input type="checkbox"/> Recent Viral Vaccinations or Infections specify date _____ <input type="checkbox"/> Abnormal laboratory results specify date _____	Cardiovascular <input type="checkbox"/> Myocarditis <input type="checkbox"/> Pericarditis <input type="checkbox"/> Endocarditis Gastrointestinal <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Other _____ Central Nervous System <input type="checkbox"/> Headache <input type="checkbox"/> Stiff neck <input type="checkbox"/> Abnormal CSF <input type="checkbox"/> Microcephalus <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Other _____
	Miscellaneous <input type="checkbox"/> Immunodeficient <input type="checkbox"/> Immunosuppressed <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Jaundice <input type="checkbox"/> Mucous Membrane Lesion <input type="checkbox"/> Skin Lesion <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Myalgia <input type="checkbox"/> Pleurodynia <input type="checkbox"/> Chorioretinitis <input type="checkbox"/> Other _____ Exposure/Travel History <input type="checkbox"/> Contact with a known case <input type="checkbox"/> Exposure to animal specify _____ <input type="checkbox"/> Insect bite specify _____ <input type="checkbox"/> Health care worker <input type="checkbox"/> Travel _____ <input type="checkbox"/> Antiviral therapy specify Start date _____