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 ☐ Male ☐ 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	Date Collected	Onset Date
☐ Stool ☐ NPS ☐ Genital ☐ Urine ☐ CSF ☐ Blood ☐ Vesicle ☐ Other ______________________________	______/______/______ MM DD YY	______/______/______ MM DD YY

Requesting Medical Provider Name and Address **Laboratory PFI** __________

Contact person________________________________**Email**_____________________________

Telephone___________________________________**Fax**________________________________

Comments
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Diagnosis ____ **Virus Suspected** _________________________

Diagnosis/Signs/Symptoms (Please check)

☐ Fever
Max. temp. ________
Duration ________

Rash
- ☐ Maculopapular
- ☐ Hemorrhagic
- ☐ Vesicular
- ☐ Other _________________

Respiratory
- ☐ Cough
- ☐ Upper Resp./Rhinitis pharyngitis
- ☐ Pneumonia, type _________________
- ☐ X-ray _________________
- ☐ Bronchitis
- ☐ Pleurisy
- ☐ Other _________________

Cardiovascular
- ☐ Myocarditis
- ☐ Pericarditis
- ☐ Endocarditis

Gastrointestinal
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Other _________________

Central Nervous System
- ☐ Headache
- ☐ Stiff neck
- ☐ Abnormal CSF
- ☐ Microcephalus
- ☐ Seizures
- ☐ Paralysis
- ☐ Other _________________

Miscellaneous
- ☐ Immunodeficient
- ☐ Immunosuppressed
- ☐ Lymphadenopathy
- ☐ Splenomegaly
- ☐ Hepatomegaly
- ☐ Jaundice
- ☐ Mucous Membrane Lesion
- ☐ Skin Lesion
- ☐ Conjunctivitis
- ☐ Myalgia
- ☐ Pleurodynia
- ☐ Chorioretinitis
- ☐ Other _________________

Exposure/Travel History
- ☐ Contact with a known case
- ☐ Exposure to animal specify __________________
- ☐ Insect bite specify _________________________
- ☐ Health care worker
- ☐ Travel ________________________________

☐ Pregnant Trimester __________________
☐ Recent Viral Vaccinations or Infections specify ________________________ date ________________________
☐ Abnormal laboratory results specify ____________________________ date ____________________________

☐ Antiviral therapy specify______________________
Start date ______________________