

**NEW YORK STATE DEPARTMENT OF HEALTH
UNKNOWN RASH DIAGNOSTICS REQUISITION FORM**

NYS Accession Number:
Date received:
Time received:

Do not ship samples without prior arrangement with Wadsworth Center Laboratory

Patient

Last Name	First Name	MI	Sex	DOB MM / DD / YYYY
Street Address	City	Zip Code	County of Residence	

Specimen

Source Swab: <input type="checkbox"/> Yes <input type="checkbox"/> No Slide: <input type="checkbox"/> Yes <input type="checkbox"/> No Vesicle/Pustule/Scab: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____	Date Collected	Submitter's Lab Number	NYS DOH Outbreak Number (if applicable)
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Submitter

Submitter Name and Address	Laboratory PFI _____	
Contact Person:	Phone:	Fax:

Reason for Testing (check one):

- Smallpox vaccination adverse event
 Was patient recently vaccinated against smallpox? Yes Date of vaccination ___/___/___ No
 If no, is contact with vaccinated person suspected? Yes No
- Suspect smallpox case (i.e., patient with fever and an acute, generalized vesicular or pustular rash)
 Risk of smallpox (using CDC criteria): High Moderate Low
*(Note: High and moderate risk cases require immediate notification of the local health department.
 High risk specimens require testing at CDC. Moderate risk specimens will be tested at LRN level C lab.
 Low risk specimens should be tested at local level or LRN level A lab.)*

Requesting Provider

Last name _____ First Name _____ Telephone_(____) _____
 Work Address _____ City _____ State _____

PLEASE SEE GUIDELINES FOR COLLECTION AND SHIPPING INSTRUCTIONS

SEND SPECIMENS TO: Dr. Nick Cirino, Room 3020, Biodefense Laboratory, Wadsworth Center, NYSDOH, David Axelrod Institute, 120 New Scotland Ave, Albany, NY 12208
Contact information: workdays 518-474-4177 non-workday 1-866-881-2809