NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Infectious Diseases Requisition

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208

Rabies Lab only: 5668 State Farm Rd, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to:
https://www.wadsworth.org/programs/id

Patient Demographics and Requesting Provider

*required information

Last name* First name* MI DOB* ☐ Male* ☐ Female* ☐ None Assigned*

Permanent Street Address Facility of Residence (if applicable) City State* ZIP Code

NYS County of Residence* Patient Telephone # Patient Reference # NYS DOH Outbreak # CDESS Case #

Race (select one or more) ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current gender identity ☐ Male (M) ☐ Female (F) ☐ Transgender M-to-F ☐ Transgender F-to-M ☐ Nonconforming ☐ Other(specify) ______

Employer Work Street Address City State ZIP Code

Occupation Work Telephone #

Name of Health Care Provider (HCP) HCP Telephone # HCP ZIP Code National Provider Identifier (NPI)

Submitting Facility (Laboratory report will be sent to this address)

*required information

Name* ______ Laboratory PFI ______

Address* ______ NPI ______

Attention to ______ Contact Person ______ Telephone # ______

Specimen Information

*required information

Collection Date* ______ Time Collected (if applicable) ______ Date of Symptom(s) Onset ______

Source(s)* ______ ☐ Primary ☐ Isolate ☐ Autopsy

Specimen submitted on/in (specify media/preservative/cell line) ______ Submitter's Specimen Identifier(s) ______

Laboratory Examination Requested

☐ Confirmation ☐ Identification/Detection Submitter Lab Findings: Smear/Stain/Other ______

☐ **Bacterial** ______
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other susceptibility (specify) ______

☐ **Parasitology** ______
- ☐ Malarial drug susceptibility

☐ **Fungal** ______
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other antifungal susceptibility

☐ **Mycobacterial** ______

☐ **Serology** ______

☐ **Viral**** ______
- ☐ Viral Encephalitis PCR Panel on CSF
- ☐ Influenza Antiviral Susceptibility

☐ **HIV/HCV** ______
- ☐ HIV Diagnostic Testing ☐ Rapid Test Confirmation
- ☐ HIV-1 RNA ☐ HIV-2 RNA ☐ HCV RNA

☐ **Other** ______

Clinical History

*required information

COVID-19 First Test* ☐ Yes ☐ No ☐ Unknown ☐ Donor Screening ☐ Pregnant (trimester) ______

Relevant Exposure: ☐ Health Care Worker ☐ Resident in a congregate care setting ☐ Contact w/Known case ☐ Travel ☐ Animal ☐ Arthropod ☐ Food/Water

Exposure Detail: ______ Hospitalized ☐ Yes ☐ No ☐ ICU Hospital Name ______

Diagnosis: ______ Fever (max): ______ CSF: Glu ______ Prot ______ RBC ______ WBC ______

Relevant Treatment ______ Date ______ Relevant Immunization ______ Date ______

****Symptoms** - Select severity: ☐ Asymptomatic ☐ Mild ☐ Severe ☐ Unknown

Check all applicable symptoms below:

Cardiovascular
- ☐ Endocarditis
- ☐ Myocarditis
- ☐ Pericarditis

Central Nervous System
- ☐ Altered Mental Status
- ☐ Encephalitis
- ☐ Headache
- ☐ Meningitis
- ☐ Paralysis

Rash
- ☐ Hemorrhagic
- ☐ Maculopapular
- ☐ Petechial
- ☐ Vesicular

Respiratory
- ☐ Bronchitis
- ☐ Cough
- ☐ Pneumonia
- ☐ Upper Respiratory

Miscellaneous
- ☐ Arthralgia
- ☐ Conjunctivitis
- ☐ Hepatitis
- ☐ Hepatomegaly
- ☐ Immunocompromised
- ☐ Lymphadenopathy
- ☐ Malaise
- ☐ Myalgia
- ☐ Splenomegaly

Other (specify)

NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Non-Human Samples

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208

Rabies Lab only: 5668 State Farm Rd, Slingerlands, NY 12159

Submitter (test ordered by)

*required information

Name*:

Address*:

Contact Person*: Phone*:

Sample Information

Collection Date*: Rabies Lab Only Second Collection Date:

NYSDOH Outbreak Number:

Collection Site:

Street Address:

City: State: ZIP Code: NYS County:

Laboratory Examination Requested

☐ Bacterial ☐ Fungal ☐ Mycobacterial ☐ Parasitic ☐ Serology ☐ Viral ☐ Other

Suspect Organism/Agent:

Animal

☐ Domestic ☐ Wild

☐ Avian ☐ Mammal ☐ Reptile ☐ Other

Common Name or Species:

Submitter Sample Number: Sample Source:

Domestic Animal Owner Name: Animal Name:

Comments:

Food

Brand Name:

Lot Number: USDA Number: Sell By Date:

Sample Description:

Comments:

Environmental

Source Description:

Describe below samples taken; use separate sheets if necessary.

Sample type (sponge, swab, water, soil, etc.)	**Identifier** (Room number, etc.)	**Sample type** (sponge, swab, water, soil, etc.)	**Identifier** (Room number, etc.)

Comments: