New York State Department of Health
Wadsworth Center
Empire State Plaza
PO Box 509, Albany, NY 12201-0509

Infectious Diseases Requisition

NYS Accession Number _____

Date received ____/____/____

Shipping address: www.wadsworth.org/wcinfo.htm

Telephone: (518) 474-4177

Patient Demographics

*denotes required information

Last Name * | First Name * | MI | DOB * ____/____/____ | ☐ Male ☐ Female Sex

Street Address | City | State | Zip Code

NYS County of Residence * | NYS DOH Outbreak Number | CDESS Case Number | Submitter's Reference Number

Submitter (Laboratory report will be sent to)

*denotes required information

Name and Address *

Name

Address

City | State | Zip

Laboratory PFI _____

Contact Person _____

Telephone Number (____)____-____ ext.____

Specimen Information

*denotes required information

Specimen is: ☐ Isolate ☑ Primary Specimen ☐ Autopsy Specimen

Collection Date * ____/____/____ (MM / DD / YYYY)

Source / Specimen Type * NP, Urine, and Serum (Circle Specimen(s) Collected)

Time Collected (if applicable for test) ____:____ (HH : MM)

Laboratory Examination Requested

www.wadsworth.org/IDtesting

☐ **Bacterial** ☐ **Fungal** ☐ **Mycobacterial** ☐ **Parasitic** ☐ **Serology** ☐ **Viral**

Suspected Organism / Agent MEASLES

☐ **Identification / Confirmation**

☐ **TB Fast Track** www.wadsworth.org/mycobac/fasttrack.htm

☐ **Viral Encephalitis Panel** www.wadsworth.org/divisions/infdis/enceph/form.htm

☐ **Susceptibility (specify antimicrobial(s))** _____

☑ **Serology (specify test and define onset date)** IgM and IgG

☑ **Other (specify)** PCR

Submitting lab findings: Smear/Stain/Other results _____ Comments _____

Specimen submitted on/in: Media _____ Preservative _____ Tissue cell line _____

Relevant Exposure: ☐ Contact known case ☐ Food/water ☐ Nosocomial

☐ Travel _____ (Location & Dates) ☐ Animal _____ (Type) ☐ Arthropod _____ (Type)

Clinical History

Name of patient's healthcare provider | (____) Telephone Number ____-____ ext.____

Diagnosis: _____ Hospitalized? ☐ Yes ☐ No ☐ Unknown If hospitalized, hospital name: _____

Pregnant (trimester): _____ Symptoms: ☐ Acute ☐ Chronic ☐ Other _____ Onset of symptoms: ____/____/____ (MM / DD / YYYY)

Fever: max _____ duration _____ CSF: Glu _____ Prot _____ RBC _____ WBC _____

Relevant Treatment: _____ Date ____/____/____ Relevant Immunization: _____ Date ____/____/____

Symptoms/Clinical Epidemiology (check all that apply):

Central Nervous System: ☐ Altered Mental Status ☐ Coma ☐ Encephalitis ☐ Headache ☐ Meningitis ☐ Paralysis ☐ Seizures

Gastrointestinal: ☐ Diarrhea ☐ Blood/Mucus ☐ Nausea ☐ Vomiting

Respiratory: ☐ Bronchitis ☐ Bronchiolitis ☐ Cough ☐ Pneumonia ☐ Upper Respiratory Infection

Skin/hair/nails: ☐ Hemorrhagic ☐ Maculopapular Rash ☐ Petechial Rash ☐ Vesicular

Cardiovascular: ☐ Endocarditis ☐ Myocarditis ☐ Pericarditis

Miscellaneous: ☐ Arthralgia ☐ Conjunctivitis ☐ Cystitis ☐ Hepatitis ☐ Hepatomegaly ☐ Immunocompromised ☐ Jaundice ☐ Keratitis ☐ Lymphadenopathy ☐ Malaise ☐ Myalgia ☐ Pleurodynia ☐ Splenomegaly ☐ Ulcer(s) ☐ Urethritis

Other Symptoms: _____

Non-Human Samples

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Submitter (test ordered by)

*denotes required information

Name and Address *

Name

Address

City State Zip

Contact Person _____

Telephone Number (____) ____- ____ ext. ____

Sample Information

*denotes required information

Collection Date * ____/____/____ (MM / DD / YYYY)

Time Collected (if applicable for test) ____:____ (HH : MM)

NYSDOH Outbreak Number _____

Laboratory Examination Requested

☐ Bacterial ☐ Fungal ☐ Mycobacterial ☐ Parasitic ☑ Serology ☐ Viral

Suspected Organism / Agent _____

Animal

☐ Domestic ☐ Wild

☐ Avian ☐ Mammal ☐ Reptile ☐ Other

Common Name _____

Sample Source _____

Submitter Sample Number _____

If domestic, name of owner and animal; if wild, specify collection site: _____

Owner/Site _____ Animal _____

Address _____ City _____ State _____ NYS County _____

Comments _____

Food

Brand Name _____ Lot Number _____ USDA Number _____

Sample description _____

Place collected _____

Street _____ City _____ State _____ NYS County _____

Comments _____

Environmental

Collection Site or Facility Name _____

Source description _____

Street _____ City _____ State _____ NYS County _____

Describe below samples taken; use separate sheets if necessary.

Sample type (Swab, etc.)	Identifier (Room number, etc.)	Sample type (Swab, etc.)	Identifier (Room number, etc.)

Comments _____