

Molecular Biology Unit - Clinical Specimen Submission Form

SUBMITTER INFORMATION

Submitter Code: - Name: _____

Street: _____ City: _____ Zip Code: _____

County: _____ State: _____

Contact Person: _____ Phone Number: (____) _____

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (M.I.) DOB ____/____/____

Patient ID: _____ Gender: M F Unknown Race: Caucasian. Black/African American Asian
 American Indian Other

Address: _____ Ethnicity - Hispanic/Latino? Yes No

City: _____ County: _____ State: _____

Patient location at time of collection: Inpatient Outpatient Long-term care

Hospitalized: Y N Hospital name: _____

Patient receiving antivirals: Y N Which Antivirals: _____

Patient receiving antibiotics: Y N Which Antibiotics: _____

Travel outside U.S within the last 10 days: Y N Destination: _____

Specimen from outbreak: Y N

Clinical Symptoms: _____ Date of onset _____

- | | | | | | |
|---|---|-------------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Backache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Cough | <input type="checkbox"/> Fever | <input type="checkbox"/> Myalgia | <input type="checkbox"/> Sore throat | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Headache | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swollen lymph nodes | |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Disordered speech | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Necrosis | <input type="checkbox"/> Vomiting | |

CLINICAL SPECIMEN INFORMATION

Date Collected: ____/____/____ Time Collected: _____

Source: _____

Culture for Identification: Source _____ Other (Specify): _____

Test Requested:

- | | | |
|---|---|--|
| <input type="checkbox"/> BT agent rule out* _____ | <input type="checkbox"/> Norovirus (rRT-PCR)* | <input type="checkbox"/> VZV (rt-PCR)* |
| <input type="checkbox"/> Influenza Panel (rRT-PCR)* | <input type="checkbox"/> Rash Panel (rt-PCR)* | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mumps (PCR)* | <input type="checkbox"/> Respiratory Panel (rRT-PCR)* | |

* Research Use Only Procedure-Requires Epidemiology Consultation