



GEORGIA DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY

MOLECULAR BIOLOGY SUBMISSION FORM

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PATIENT ID: _____
NAME: _____	NAME: _____ <small>Last First Middle</small>
STREET: _____	RESIDENCE: _____ <small>Street City State Zip</small>
CITY: _____	PHONE: _____ <small>County Home Work Cell/Other</small>
STATE _____ ZIP CODE _____	DOB: ____/____/____ Medicaid # _____
PHONE NO: _____	RACE: <input type="checkbox"/> American Indian/Alaska Native
FAX NO: _____	<input type="checkbox"/> Asian
CONTACT NAME: _____	<input type="checkbox"/> Black/African-American
	<input type="checkbox"/> Native Hawaiian/Pacific Islander
	<input type="checkbox"/> Other
	<input type="checkbox"/> Unknown
	<input type="checkbox"/> White
	ETHNICITY: <input type="checkbox"/> Hispanic or Latino
	<input type="checkbox"/> Non-Hispanic or Latino
	<input type="checkbox"/> Unknown
	GENDER: <input type="checkbox"/> Male
	<input type="checkbox"/> Female
	<input type="checkbox"/> Unknown

SPECIMEN/CLINICAL INFORMATION		
Date of collection: ____/____/____ Time of collection: _____ Source: _____ Specimen type: <input type="checkbox"/> Clinical _____ <input type="checkbox"/> Culture <input type="checkbox"/> Other Specimen shipped: <input type="checkbox"/> Frozen <input type="checkbox"/> Refrigerated <input type="checkbox"/> Room Temperature Special instructions (if any): _____	Clinical information: Date of onset: ____/____/____ Patient location at time of collection: <input type="checkbox"/> Inpatient <small>Hospital name _____</small> <input type="checkbox"/> Outpatient <input type="checkbox"/> Long term care Patient receiving antivirals: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient receiving antibiotics: <input type="checkbox"/> Yes <input type="checkbox"/> No Outbreak related: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name/ID# of outbreak: _____ Travel outside US (within last 10 days): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____	Symptoms: (check all that apply): <input type="checkbox"/> Backache <input type="checkbox"/> Blurred vision <input type="checkbox"/> Chest pain <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Disordered speech <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Joint pain <input type="checkbox"/> Myalgia <input type="checkbox"/> Nausea <input type="checkbox"/> Necrosis <input type="checkbox"/> Vomiting <input type="checkbox"/> Rash <input type="checkbox"/> Sore throat <input type="checkbox"/> Stiff neck <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Watery/red/itchy eyes <input type="checkbox"/> Weight loss <input type="checkbox"/> Other _____ Influenza rapid test results (if performed): _____

Please select ONLY one TEST per SPECIMEN per FORM

Test requested	Results
<input type="checkbox"/> BT agent rule out* _____ <input type="checkbox"/> Bordetella pertussis (PCR)* <input type="checkbox"/> Influenza panel (rRT-PCR)* <input type="checkbox"/> Mumps (PCR)* <input type="checkbox"/> Norovirus (rRT-PCR)* <input type="checkbox"/> Rash illness panel (PCR)* <input type="checkbox"/> VZV (PCR)* <input type="checkbox"/> Refer to CDC* <input type="checkbox"/> Other: _____ <small>* Research use only procedure- requires epidemiology consultation</small>	 Date reported: _____ Reported by: _____