GEORGIA DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY

VIROLOGY SUBMISSION FORM

SUBMITTER INFORMATION

SUBMITTER CODE: ☐☐☐☐☐☐

CLINIC NAME: ____________________________________

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STREET: ____

CITY: ____

STATE ________ ZIP CODE: ________________________

PHONE NO: ______________________________________

FAX NO: ____

CONTACT NAME:

____

PATIENT INFORMATION

PATIENT ID: ____________________________ CTS#: ________________________

NAME: ____
Last First Middle

RESIDENCE: ____
Street City State Zip

____________________ PHONE: ________________________
County Home Work Cell/other

DOB: _____/______/________ Medicaid #_______________________________

RACE:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Unknown
- ☐ White

ETHNICITY:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown

GENDER:
- ☐ Male
- ☐ Female
- ☐ Unknown

SPECIMEN INFORMATION

Date of Collection:

_____/______/___________

Source/Type:
- ☐ Blood
- ☐ CSF
- ☐ Lesion/General Swab
- ☐ Lesion/Genital Swab
- ☐ Nasopharyngeal Aspirate
- ☐ Nasopharyngeal Swab
- ☐ Plasma
- ☐ Rectal Swab
- ☐ Serum
- ☐ Stool
- ☐ Throat Swab
- ☐ Urine
- ☐ Other: ___________________

Reason for Testing:
- ☐ Court Ordered
- ☐ Diagnosis
- ☐ Outbreak
- ☐ Rapid Test Confirmation
- ☐ Routine Screening
- ☐ Other: ___________________

Shipped:
- ☐ Frozen
- ☐ Refrigerated
- ☐ Room Temperature

Special Instructions:

____

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Forward to CDC**

Clinical Information:

Date of Onset: ________________________________

Previous Lab Results, if any: ____________________

Outbreak Related: ☐ Yes ☐ No
If Yes, Name/ID# of outbreak:

____

Travel Outside US: Yes No
If Yes, where? : ______________________________

Symptoms: (check all that apply)
- ☐ chills/body aches
- ☐ diarrhea
- ☐ headache
- ☐ stiff neck
- ☐ watery/red/itchy eyes
- ☐ cough
- ☐ fever
- ☐ rash
- ☐ vomiting
- ☐ other_____________

Please select ONLY one TEST per SPECIMEN per FORM

HIV

Test requested:

- ☐ HIV 1/2 plus O EIA
- ☐ HIV-1 Ab WB
- ☐ HIV-2 Ab

Ryan White Care Act Clients Only
- ☐ HIV-1 Viral Load (bDNA)

- ☐ Other: ____________________________________

VIRAL CULTURE

Test requested:

- ☐ CMV Culture/IFA
- ☐ Enterovirus Culture/IFA
- ☐ Gastrointestinal Outbreak Investigation
  - ☐ Norovirus Panel (EM/PCR)
  - ☐ Rotavirus EIA
- ☐ Herpes Culture/ELVIS
- ☐ Respiratory Panel/IFA
  - ☐ Adenovirus Culture/IFA
  - ☐ Influenza Culture/IFA
  - ☐ Parainfluenza Culture/IFA
  - ☐ RSV Culture/IFA
  - ☐ Other respiratory__________/IFA
- ☐ VZV Culture/IFA
- ☐ Viral Culture/Identification (Please specify):

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