Virus Detection History

New York State Department of Health
Wadsworth Center, Empire State Plaza
Virus Reference and Surveillance Laboratory
P.O. Box 509
Albany, New York 12201-0509
Phone (518) 869-4500 Fax (518) 869-6487

* Please see instructions for shipping address

NYS Lab Number

Date Received

Please type or print legibly in black ink

Patient

Last Name	First Name	MI	DOB _____/_____/____ MM DD YY	Sex ☐ Male ☐ Female

Street Address	City/State	Zip Code	County of Residence

Specimen

☐ Original Material ☐ Isolate Cell line_____ ☐ Autopsy ☐ Biopsy

NYS DOH Outbreak # _____ CDESS Case ID _____ Submitter Lab # _____

DOH Influenza Sentinel Specimen ☐ Yes ☐ No SARS suspect ☐ Yes ☐ No ☐ Calicivirus testing

Source	Date Collected	Onset Date
☐ Stool ☐ NPS ☐ Genital ☐ Urine ☐ CSF ☐ Blood ☐ Vesicle ☐ Other _____	_____/_____/_____ MM DD YY	_____/_____/_____ MM DD YY

Requesting Medical Provider Name and Address **Laboratory PFI** _____

Contact person_____**Email**_____

Telephone_____**Fax**_____

Comments

_____

_____

_____

_____

_____

_____

Diagnosis _____ **Virus Suspected** _____

Diagnosis/Signs/Symptoms (Please check)

☐ Fever
Max. temp. _____
Duration _____

Rash
☐ Maculopapular
☐ Hemorrhagic
☐ Vesicular
☐ Other _____

Respiratory
☐ Cough
☐ Upper Resp./Rhinitis pharyngitis
☐ Pneumonia, type _____
☐ X-ray _____
☐ Bronchitis
☐ Pleurisy
☐ Other _____

Cardiovascular
☐ Myocarditis
☐ Pericarditis
☐ Endocarditis

Gastrointestinal
☐ Diarrhea
☐ Nausea/Vomiting
☐ Other _____

Central Nervous System
☐ Headache
☐ Stiff neck
☐ Abnormal CSF
☐ Microcephalus
☐ Seizures
☐ Paralysis
☐ Other _____

Miscellaneous
☐ Immunodeficient
☐ Immunosuppressed
☐ Lymphadenopathy
☐ Splenomegaly
☐ Hepatomegaly
☐ Jaundice
☐ Mucous Membrane Lesion
☐ Skin Lesion
☐ Conjunctivitis
☐ Myalgia
☐ Pleurodynia
☐ Chorioretinitis
☐ Other _____

Exposure/Travel History
☐ Contact with a known case
☐ Exposure to animal specify _____
☐ Insect bite specify _____
☐ Health care worker
☐ Travel _____

☐ Pregnant Trimester _____
☐ Recent Viral Vaccinations or Infections specify _____
date _____
☐ Abnormal laboratory results specify _____
date _____

☐ Antiviral therapy specify_____
Start date _____