Lab Use Only

☐ **Acceptance Criteria Not Met**
- ☐ Inappropriate temperature
- ☐ Specimen too old
- ☐ Incomplete labeling/form
- ☐ Specimen inappropriate/damaged

Date: ___/___/____ Initials:_____

VIROLOGY

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested *Attach Printed Label Below*

Patient Information

Last Name				
First Name	MI			
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
SSN: _____			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:		Date of Birth: ___/___/_____		If Female, Pregnant? ☐ Yes ☐ No ☐ Unknown
Sex: ◯ Male ◯ Female ◯ Unknown ◯ Ambiguous ◯ Transgender M2F ◯ Transgender F2M ◯ Transgender Unknown		Race (mark all that apply): ☐ White ☐ Black ☐ Asian ☐ Unknown ☐ American Indian/ Alaska Native ☐ Native Hawaiian/ Pacific Isles		Ethnicity: ☐ Hispanic or Latino Origin ☐ Non-Hispanic ☐ Unknown
Clinic/Program Type: ☐ Prenatal ☐ Family Planning ☐ Other (specify): _____				

Submitter

EIN: _____-_____	Submitter Name:	
Address:	Address 2:	City:
State:	Zip Code:	County Name:
Phone Number:	Email Address:	Fax Number:
Ordering Provider NPI:	Ordering Provider First and Last Name:	

Specimen

Specimen source(s):	Collection Date(s) and Times(s):	Collector's Initials	Laboratory Number(s): *Do Not Write in this Space*
(a)	___/___/____ ___:___ 24 Hr Time		
(b)	___/___/____ ___:___ 24 Hr Time		
(c)	___/___/____ ___:___ 24 Hr Time		
(d)	___/___/____ ___:___ 24 Hr Time		

Onset Date: ___/___/_____	NC PUI Number: _____	Reason for Testing (ICD-10 Dx Code): _____

Infectious Agent(s) Suspected or Test(s) Requested: *(Check one or more boxes, as needed)*

☐ Comprehensive Viral Culture ☐ Mumps ☐ HSV/VZV
☐ Influenza ☐ Measles ☐ Other (specify) _____

Other Patient Information

Patient Signs and Symptoms: *(Check all that apply)*

Genital	General	Rash	Respiratory	GNC	Cardiovascular
☐ Vesicles	☐ Fever to_____°F	☐ Macular	☐ Cough	☐ Seizures	☐ Chest Pain
☐ PID	☐ Headache	☐ Papular	☐ Pneumonia	☐ Meningitis	☐ Pericarditis
☐ Cervicitis	☐ Fatigue	☐ Vesicular	☐ Bronchitis	☐ Encephalitis	☐ Myocarditis
☐ Urethritis	☐ Sore Throat	☐ Petechial	☐ Croup	☐ Nuchal rigidity	☐ Pleurodynia
☐ Hysterectomy	☐ Jaundice	☐ Focal	☐ Pharyngitis	☐ Paralysis	
☐ Mucopurulent Discharge	☐ Conjunctivitis	☐ Hemorrhagic			
☐ Atypical Lesion	☐ Arthralgia/Myalgia				
	☐ Nausea/Vomiting				
	☐ Diarrhea				

If pregnant, due date:____/____/____

Patient Expired? ☐ Yes Date:____/____/_____

Recent Vaccination History:

_____

_____

_____

_____

Travel History:

Area(s): _____

_____

_____

Dates: _____

For Laboratory Use Only

Temperature on Arrival: ❑ Frozen ❑ Cold ❑ Ambient Date received:____/____/_____

Comments:

- ❑ Four or more days between collection and receipt of specimen
- ❑ Specimen broken or leaked in transit
- ❑ Specimen received ambient
- ❑ Other _____

Unsatisfactory Specimen:

- ❑ No name on specimen
- ❑ Name on specimen/form do not match
- ❑ Specimen broken/leaked
- ❑ Collected in incorrect transport media
- ❑ Other _____

Interpretation:

- ❑ Negative: No virus detected
- ❑ Virus identified by molecular assay _____
- ❑ Virus identified by culture _____

Results Telephoned:

To:_____

Date/Time:_____

By: _____