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):	Collector's Initials	Laboratory Number(s): *Do Not Write in this Space*
(a)	__ __/__ __/__ __ __ __		
(b)	__ __/__ __/__ __ __ __		
(c)	__ __/__ __/__ __ __ __		
(d)	__ __/__ __/__ __ __ __		

Onset Date: __ __/__ __/__ __ __ __	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: _____