California Department of Public Health – Viral and Rickettsial Disease Laboratory

Specimen Submittal Form

Patient's last name, first name			Patient's mailing address (including Zip code)	Route to: [ ] SERO [ ] ISOL [ ] FA [ ] RAB [ ]
Age or DOB:	Sex (circle): M F	Onset Date:		
Disease suspected or test requested:			**This section for Virus Laboratory use only. Date received by VRDL and State Accession Number**	
1st	Specimen type and/or specimen source	Date Collected	1st	[ ] BE [ ] LC [ ] _____
2nd	Specimen type and/or specimen source	Date Collected	2nd	[ ] _____ [ ] _____ [ ] _____
			Submit specimens to: **County of Riverside Department of Public Health Disease Control Branch 4065 County Circle Dr. Riverside, Ca. 92503**	[ ] E IgM [ ] E PCR [ ] H PCR [ ] C PCR [ ] _____ code:

Type or print submitter's complete mailing address above

Lab 300 Rev. 09/17/2007

Clinical Information (fill in or check as pertinent)

Patient is not ill Date of Last Immunization

[ ] Vaccine response

____

[ ] Case contact to

____

[ ] Mother of infant with congenital disease

[ ]

Other______________________________

Is Patient Immunocompromised? [ ] Yes [ ] No

Clinical Findings

[ ] Fever- [ ] Chills

[ ] Generalized aches [ ] Joint aches or stiffness

[ ] Malaise [ ] Conjunctivitis

[ ] Headache [ ] Jaundice

[ ] Lymphadenopathy [ ] Hepatosplenomegaly

[ ] Hepatitis [ ] Rash (describe below)

[ ] Other

Central Nervous System

[ ] Encephalitis [ ] Febrile headache

[ ] Meningitis

Gastroenteritis [ ] Individual case [ ] Outbreak

Respiratory

[ ] Upper respiratory infection

[ ] Cough

[ ] Croup

[ ] Pharyngitis

[ ] Bronchiolitis / Bronchitis

[ ] Pneumonia

[ ] ARDS (acute respiratory distress syndrome)

[ ]

Other______________________________

Cardiovascular [ ] Myocarditis / Pericarditis

Urogenital

[ ] Urethritis [ ] Cervicitis

[ ] Vaginal lesion(s) [ ] Penile lesion(s)

Oral

[ ] Mouth lesion(s) [ ] Lip lesion(s)

Congenital Disease (describe below)

Please provide other clinical findings and/or pertinent laboratory data: Note - If disease suspected is Rickettsial or not endemic to California, please include travel history and/or vector exposure information (date bitten and type of vector).

Specialty forms for respiratory disease, encephalitis, West Nile Virus, Hantavirus pulmonary syndrome (HPS) Severe Pediatric Respiratory, viral Gastroenteritis and other syndromes are also available. These forms can be faxed to you upon request by calling (510) 307-8575.

Submitting Physician: ____________________ *Phone#* (951) 358-5107______

Submitting Facility: ____________________ *Fax#* (_____) __________