

<b>LABORATORY EXAMINATION(S) REQUESTED:</b> <input type="checkbox"/> ANtimicrobial Susceptibility <input type="checkbox"/> ISolation <input type="checkbox"/> HIstology <input type="checkbox"/> SErology (Specific Test) <input type="checkbox"/> IDentification <input type="checkbox"/> OTHer (Specify)			<b>CATEGORY OF AGENT SUSPECTED:</b> <input type="checkbox"/> BActerial <input type="checkbox"/> RIckettsial <input type="checkbox"/> VIral <input type="checkbox"/> PArasitic <input type="checkbox"/> FUngal <input type="checkbox"/> OTHer (Specify)			
<b>SPECIFIC AGENT SUSPECTED:</b> 	<b>OTHER ORGANISM(S) FOUND:</b> 	<b>ISOLATION ATTEMPTED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>NO. OF TIMES ISOLATED:</b> 	<b>NO. OF TIMES PASSED:</b> 	<b>SPECIMEN SUBMITTED IS:</b> <input type="checkbox"/> Original Material <input type="checkbox"/> Mixed Isolate <input type="checkbox"/> Pure Isolate	
<b>DATE SPECIMEN TAKEN:</b> MO / DA / YR	<b>ORIGIN:</b> <input type="checkbox"/> FOod <input type="checkbox"/> ANimal <input type="checkbox"/> OTHer (Specify) <input type="checkbox"/> HUman <input type="checkbox"/> SOil (Specify)					
<b>SOURCE OF SPECIMEN:</b> <input type="checkbox"/> BLood <input type="checkbox"/> CSF <input type="checkbox"/> WOund (Site) <input type="checkbox"/> GAstic <input type="checkbox"/> HAir <input type="checkbox"/> EXudate (Site) <input type="checkbox"/> SErum <input type="checkbox"/> SKin <input type="checkbox"/> TIssue (Specify) <input type="checkbox"/> SPutum <input type="checkbox"/> STool <input type="checkbox"/> OTHer (Specify) <input type="checkbox"/> URine <input type="checkbox"/> THroat <input type="checkbox"/> OTHer (Specify)			<b>SUBMITTED ON:</b> <input type="checkbox"/> MEidium <input type="checkbox"/> ANimal <input type="checkbox"/> TIssue Culture (Type) <input type="checkbox"/> EGg <input type="checkbox"/> OTHer (Specify)			
<b>SERUM INFORMATION:</b> MO / DA / YR <input type="checkbox"/> ACute <input type="checkbox"/> COnvalescent <input type="checkbox"/> S3 <input type="checkbox"/> S4 <input type="checkbox"/> S5			<b>SIGNS AND SYMPTOMS:</b> <input type="checkbox"/> FEver    Maximum Temperature: _____ Duration: _____ Days <input type="checkbox"/> CHills		<b>CENTRAL NERVOUS SYSTEM:</b> <input type="checkbox"/> HEadache <input type="checkbox"/> MEningismus <input type="checkbox"/> MIcrocephalus <input type="checkbox"/> HYdrocephalus <input type="checkbox"/> SEizures <input type="checkbox"/> CErebral Calcification <input type="checkbox"/> CHorea <input type="checkbox"/> PAralysis <input type="checkbox"/> OTHer	
<b>IMMUNIZATIONS:</b> MO / YR (1.) _____ (2.) _____ (3.) _____ (4.) _____			<b>SKIN:</b> <input type="checkbox"/> MAculopapular <input type="checkbox"/> HEmorrhagic <input type="checkbox"/> VEsicular <input type="checkbox"/> Erythema Nodosum <input type="checkbox"/> Erythema Marginatum <input type="checkbox"/> OTHer		<b>MISCELLANEOUS:</b> <input type="checkbox"/> JAundice <input type="checkbox"/> MYalgia <input type="checkbox"/> PLeurodynia <input type="checkbox"/> COnjunctivitis <input type="checkbox"/> CHorioretinitis <input type="checkbox"/> SPlenomegaly <input type="checkbox"/> HEpatomegaly <input type="checkbox"/> LIver Abscess/cyst <input type="checkbox"/> LYmphadenopathy <input type="checkbox"/> MUcous Membrane Lesions <input type="checkbox"/> OTHer	
<b>TREATMENT: DRUGS USED</b> <input type="checkbox"/> None MO / DA / YR    DATE BEGUN    DATE COMPLETED (1.) _____ (2.) _____ (3.) _____			<b>RESPIRATORY:</b> <input type="checkbox"/> RHinitis <input type="checkbox"/> PUlmonary <input type="checkbox"/> PHaryngitis <input type="checkbox"/> CAlcifications <input type="checkbox"/> OtItis Media <input type="checkbox"/> PNeumonia (type) <input type="checkbox"/> OTHer		<b>STATE OF ILLNESS:</b> <input type="checkbox"/> SYmptomatic <input type="checkbox"/> ASymptomatic <input type="checkbox"/> SUBacute <input type="checkbox"/> CHronic <input type="checkbox"/> DIsseminated <input type="checkbox"/> LOcalized <input type="checkbox"/> EXtraintestinal <input type="checkbox"/> OTHer	
<b>EPIDEMIOLOGICAL DATA:</b> <input type="checkbox"/> Single Case <input type="checkbox"/> SPoradic <input type="checkbox"/> COntact <input type="checkbox"/> EPidemic <input type="checkbox"/> CArrier Family Illness _____ Community Illness _____ <b>Travel and Residence (Location)</b> <input type="checkbox"/> Foreign <input type="checkbox"/> USA Animal Contacts (Species) _____ Anthropod Contacts: <input type="checkbox"/> None <input type="checkbox"/> Exposuer Only <input type="checkbox"/> Bite Type of Anthropod: _____ Suspected Source of Infection: _____						
<b>PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION:</b> (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.						
			UNIT	FY	NUMBER	
			SUF.			

*Justification must be completed by State health department laboratory before specimen can be accepted by CDC. Please check the first applicable statement and when appropriate complete the statement with the \*.*

1. Disease suspected to be of public health importance. Specimen is:  
 (a)  from an outbreak. (b)  from uncommon or exotic disease.  
 (c)  an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d)  from a disease for which reliable diagnostic reagents or expertise are unavailable in State.

2.  Ongoing collaborative CDC/State project.  
 3.  Confirmation of results requested for quality assurance.

\*Prior arrangement for testing has been made.  
 Please bring to the attention of:  
 (Name): \_\_\_\_\_

Completed by: \_\_\_\_\_  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

STATE HEALTH DEPARTMENT LABORATORY ADDRESS: \_\_\_\_\_

STATE HEALTH DEPT. NO.: \_\_\_\_\_ DATE SENT TO CDC: (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT IDENTIFICATION: (Hospital No.) \_\_\_\_\_

NAME: (LAST, FIRST, MI) \_\_\_\_\_

BIRTHDATE: (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  MALE  FEMALE

CLINICAL DIAGNOSIS: \_\_\_\_\_

ASSOCIATED ILLNESS: \_\_\_\_\_

DATE OF ONSET: (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ FATAL?  YES  NO

(FOR CDC USE ONLY)		CDC NUMBER		DATE RECEIVED		
UNIT	FY	NUMBER	SUF	MO	DA	YR

**REVERSE SIDE OF THIS FORM MUST BE COMPLETED**

**THIS FORM MUST BE EITHER PRINTED OR TYPED  
 PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN**

**D.A.S.H.**

**DATE REPORTED**

MO DA YR

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Comments:

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
 Public Health Service  
 Centers for Disease Control  
 Center for Infectious Diseases  
 Atlanta, Georgia 30333



The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.