LABORATORY EXAMINATION(S) REQUESTED:

☐ **AN**timicrobial Susceptibility ☐ **IS**olation
☐ **HI**stology ☐ **SE**rology (Specific Test) _____
☐ **ID**entification ☐ **OT**her (Specify) _____

CATEGORY OF AGENT SUSPECTED:

☐ **BA**cterial ☐ **RI**ckettsial
☐ **VI**ral ☐ **PA**rasitic
☐ **FU**ngal ☐ **OT**her (Specify) _____

SPECIFIC AGENT SUSPECTED:	OTHER ORGANISM(S) FOUND:	ISOLATION ATTEMPTED?	NO. OF TIMES ISOLATED:	NO. OF TIMES PASSED:	SPECIMEN SUBMITTED IS:
		☐ YES ☐ NO			☐ Original Material ☐ Mixed Isolate ☐ Pure Isolate

DATE SPECIMEN TAKEN: ___/___/___ (MO DA YR)

ORIGIN: ☐ **HU**man ☐ **FO**od ☐ **SO**il ☐ **AN**imal (Specify) _____ ☐ **OT**her (Specify) _____

SOURCE OF SPECIMEN:

☐ **BL**ood ☐ **CSF** ☐ **GA**stric ☐ **HA**ir ☐ **SE**rum ☐ **SK**in ☐ **SP**utum ☐ **ST**ool ☐ **UR**ine ☐ **TH**roat

☐ **WO**und (Site) _____
☐ **EX**udate (Site) _____
☐ **TI**ssue (Specify) _____
☐ **OT**her (Specify) _____

SUBMITTED ON:

☐ **ME**dium _____
☐ **AN**imal _____
☐ **TI**ssue Culture (Type) _____
☐ **EG**g ☐ **OT**her (Specify) _____

SERUM INFORMATION:

	MO	DA	YR		MO	DA	YR
☐ **AC**ute				☐ **S3**			
☐ **CO**nvalescent				☐ **S4**			
				☐ **S5**			

IMMUNIZATIONS:

	MO	YR
(1.) _____		
(2.) _____		
(3.) _____		
(4.) _____		

TREATMENT: DRUGS USED ☐ None

	DATE BEGUN MO	DA	YR	DATE COMPLETED MO	DA	YR
(1.) _____						
(2.) _____						
(3.) _____						

EPIDEMIOLOGICAL DATA:

☐ **SI**ngle Case ☐ **SP**oradic ☐ **CO**ntact ☐ **EP**idemic ☐ **CA**rrier

Family Illness _____

Community Illness _____

Travel and Residence (Location)

☐ **Foreign** _____

☐ **USA** _____

Animal Contacts (Species) _____

Anthropod Contacts: ☐ None ☐ Exposuer Only ☐ Bite

Type of Anthropod: _____

Suspected Source of Infection: _____

SIGNS AND SYMPTOMS:

☐ **FE**ver
Maximum Temperature: _____
Duration: _____ Days
☐ **CH**ills

SKIN:

☐ **MA**culopapular
☐ **HE**morrhagic
☐ **VE**sicular
☐ Erythema **N**odosum
☐ Erythema **M**arginatum
☐ **OT**her

RESPIRATORY:

☐ **RH**initis
☐ **PU**lmonary
☐ **PH**aryngitis
☐ **CA**lcifications
☐ **O**titis **M**edia
☐ **PN**eumonia (type)
☐ **OT**her

CARDIOVASCULAR:

☐ **MY**ocarditis
☐ **PE**ricarditis
☐ **EN**docarditis
☐ **OT**her

GASTROINTESTINAL:

☐ **DI**arrhea
☐ **BL**ood
☐ **MU**cous
☐ **CO**nstipation
☐ **AB**normal Pain
☐ **VO**miting
☐ **OT**her

CENTRAL NERVOUS SYSTEM:

☐ **HE**adache
☐ **ME**ningismus
☐ **MI**crocephalus
☐ **HY**drocephalus
☐ **SE**izures
☐ **CE**rebral Calcification
☐ **CH**orea
☐ **PA**ralysis
☐ **OT**her

MISCELLANEOUS:

☐ **JA**undice
☐ **MY**algia
☐ **PL**eurodynia
☐ **CO**njunctivitis
☐ **CH**orioretinitis
☐ **SP**lenomegaly
☐ **HE**patomegaly
☐ **LI**ver Abscess/cyst
☐ **LY**mphadenopathy
☐ **MU**cous Membrane Lesions
☐ **OT**her

STATE OF ILLNESS:

☐ **SY**mptomatic
☐ **AS**ymptomatic
☐ **SU**bacute
☐ **CH**ronic
☐ **DI**sseminated
☐ **LO**calized
☐ **EX**traintestinal
☐ **OT**her

PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION: (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.

CDC NUMBER

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: __ __/__ __/__ __ __ __

Name, Address and Phone Number of Physician or Organization:

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