

# VIROLOGY

N.C. Department of Health and Human Services  
 State Laboratory of Public Health  
 4312 District Drive  
 Raleigh, NC 27607

<b>Lab Use Only</b>	<input type="checkbox"/> <b>Acceptance Criteria Not Met</b>
	<input type="checkbox"/> Inappropriate temperature
	<input type="checkbox"/> Specimen too old
	<input type="checkbox"/> Incomplete labeling/form
	<input type="checkbox"/> Specimen inappropriate/damaged
Date: ___/___/___    Initials: _____	

Please Give All Information Requested

Attach Printed Label Below

<b>Patient Information</b>	Last Name			
	First Name	MI		
	Maiden Name/Surname			
	Address/Attention:			
	Street Address:		Address 2:	City:
	State:	Zip Code:	County Code:	County Name:
	Insurance ID Number: (if applicable)		Medicaid Number (if applicable):	
	Medical Record Number:		Date of Birth: ___/___/___	If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous		Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown <input type="checkbox"/> Pacific Isles	
	Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			
Clinic/Program Type: <input type="checkbox"/> Prenatal <input type="checkbox"/> Family Planning <input type="checkbox"/> Other (specify): _____				
<b>Submitter</b>	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:	
<b>Specimen</b>	Specimen source(s):	Collection Date(s) and Times(s):	Collector's Initials	Laboratory Number(s): <i>Do Not Write in this Space</i>
	(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): _____	
<b>Infectious Agent(s) Suspected or Test(s) Requested:</b> <i>(Check one or more boxes, as needed)</i>				
<input type="checkbox"/> Comprehensive Viral Culture <input type="checkbox"/> Mumps <input type="checkbox"/> HSV/VZV <input type="checkbox"/> Influenza <input type="checkbox"/> Measles <input type="checkbox"/> Other (specify) _____				

Other Patient Information

Patient Signs and Symptoms: (Check all that apply)

**Genital**

- Vesicles
- PID
- Cervicitis
- Urethritis
- Hysterectomy
- Mucopurulent Discharge
- Atypical Lesion

**General**

- Fever to \_\_\_\_\_ °F
- Headache
- Fatigue
- Sore Throat
- Jaundice
- Conjunctivitis
- Arthralgia/Myalgia
- Nausea/Vomiting
- Diarrhea

**Rash**

- Macular
- Papular
- Vesicular
- Petechial
- Focal
- Hemorrhagic

**Respiratory**

- Cough
- Pneumonia
- Bronchitis
- Croup
- Pharyngitis

**GNC**

- Seizures
- Meningitis
- Encephalitis
- Nuchal rigidity
- Paralysis

**Cardiovascular**

- Chest Pain
- Pericarditis
- Myocarditis
- Pleurodynia

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: \_\_\_\_\_