State of Washington
Department of Health
PUBLIC HEALTH LABORATORIES
1610 N.E. 150th Street
Shoreline, Washington 98155-9701
Phone: (206) 418-5400
Fax: (206) 418-5545
MTS #1327 CLIA #50D0661453
Http://WWW.DOH.WA.GOV/EHSPHL/PHL

SEROLOGY/VIROLOGY/HIV

FOR PHL USE ONLY

Lab Number Date/Time Received

Please Print Clearly

PATIENT

NAME (LAST)

(FIRST) (MI)

ADDRESS

CITY STATE ZIP CODE

MALE FEMALE | DATE OF BIRTH MO DAY YR | COUNTY

CHART OR PATIENT ID NUMBER | PT PHONE: ( )

PHYSICIAN | PHYSICIAN'S PHONE # ( ) -

SUBMITTER

NAME OF PERSON COMPLETING THIS FORM | PHONE # ( ) -

MAIL RESULTS TO:

CITY, STATE, ZIP CODE:

COUNTY

AREA CODE & PHONE # ( ) - | FAX # ( ) -

THIS SECTION IS REQUIRED

Testing for 2009 H1N1 influenza virus will only be performed if one of the following criteria are met:

☐ Yes ☐ No	Death suspected due to influenza **OR**
☐ Yes ☐ No	Patient in intensive care unit with suspected influenza **OR**
☐ Yes ☐ No	Hospitalized patient with positive influenza test **OR**
☐ Yes ☐ No	Pregnant woman with positive influenza test **OR**
☐Yes ☐ No	Designated sentinel provider for influenza **OR**
☐Yes ☐ No	Designated sentinel laboratory for influenza **OR**
☐Yes ☐ No	Approved by local health jurisdiction Staff member name:______________________

DOH 302-013 (01/2007)

SPECIMEN INFORMATION

ATTENTION: (See Instructions on Reverse Side of Form)

◯ SYPHILIS SEROLOGY X VIRUS ◯ HIV

SPECIFIC AGENT SUSPECTED: 2009 H1N1 virus

DATE COLLECTED	MO	DAY	YR	TIME OF DAY ___:___	◯ AM ◯ PM
DATE OF ONSET	MO	DAY	YR	TIME OF DAY ___:___	◯ AM ◯ PM
DATE SENT TO STATE	MO	DAY	YR	FATAL?	◯ YES ◯ NO

SUBMITTER'S LAB NUMBER:

TYPE OF SPECIMEN

◯ SERUM/BLOOD ◯ CSF ◯ NP/THR ◯ ORASURE

◯ OTHER (SPECIFY) ____________

VIRUS EXAMINATIONS

Chief Clinical Findings. (check system involved and list chiefs symptoms)

X Respiratory ____________

◯ Central Nervous System ____________

◯ Cutaneous Eruptions-Location and Type ____________

◯ Other ____________

Optimally, collect isolation specimen within 3 days of onset. Submit each specimen as soon as collected. Keep at refigerator temperatures. 24 hour delivery is perferred

SYPHILIS SEROLOGY

Reason For Test

◯ Treatment Control (VDRL only, Syphilis already confirmed)

◯ Diagnostic/Screen (VDRL as screen, if reactive TPPA will be performed for confirmation

◯ Prenatal (Screen due to pregnancy)

◯ Reference (VDRL and TPPA performed, Clinical history indicative of Syphilis)

◯ Premarital State ____________ (Required for Marriage LIcense)

SYMPTOMS

◯ NO ◯ YES ____________

(If yes, list symptoms. Check REFERENCE)

PREVIOUS TEST RESULT: (Please list any previous test results pertaining to specimen submission)

◯ VDRL__________ ◯ RPR__________ ◯ OTHER__________

HIV

TYPE OF TEST REQUESTED: ◯ ELISA ◯ WESTERN BLOT

PREVIOUS HIV TEST DONE? ◯ YES ◯ NO ◯ DON'T KNOW ◯ DECLINED

IF YES, TYPE OF TEST DONE: ◯ Conventional ◯ Rapid ◯ Other__________

SAMPLE TYPE: ◯ Blood-Finger Stick ◯ Blood - Venipuncture ◯ Blood Spot ◯ Oral Mucosal Transudate ◯ Other__________

RESULT: ◯ Positive ◯ Negative ◯ Preliminary Positive ◯ Indeterminant ◯ Don't Know ◯ Declined ◯ Not Asked

HAS A PREVIOUS SPECIMEN ON THIS PATIENT BEEN TESTED AT THE STATE LAB?

◯ YES ◯ NO STATE LAB NUMBER __________

FOR PHL USE ONLY

Date/Time Reported:

September 11, 2009