OUTBREAK SEROLOGY REQUEST

State Form 53761 (11-08)
CLIA Certified Laboratory #15D0662599

Reset Form

INDIANA STATE DEPARTMENT OF HEALTH LABORATORIES
550 W. 16TH STREET, SUITE B
INDIANAPOLIS, IN 46202

SECTION 1. PATIENT DEMOGRAPHICS

Last Name _____ First Name _____ MI _____ Date of Birth ____/____/____

Patient ID _____ City / County of Residence _____ State _____ ZIP Code _____

Race:

☐ Asian
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Multiracial
☐ Other
☐ Unknown

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Sex:

☐ Male ☐ Female ☐ Unknown

Name of ☐ Employer ☐ School ☐ Care Facility ☐ Institution _____ Facility Phone Number ____ - ____ - ____ Occupation _____

Institution Resident? ☐ Yes ☐ No Institution Type ☐ Prison ☐ Nursing Home ☐ Other (specify) _____

Staff? ☐ Yes ☐ No

SECTION 2. SPECIMEN INFORMATION

☐ Blood ☐ Serum ☐ CSF Date of onset ____/____/____ Date collected: Acute____/____/_____ Convalescent____/____/_____

Is specimen part of a public health investigation? ☐ Yes ☐ No ☐ Unknown Is patient immunocompromised? ☐ Yes ☐ No

SECTION 3. TEST SELECTION

Agent suspected_____

☐ Hepatitis A
☐ Measles IgM
☐ Measles IgG
☐ Rubella IgM
☐ Rubella IgG
☐ Mumps IgM
☐ Mumps IgG
☐ Varicella IgM
☐ Varicella IgG
☐ Legionella
☐ Hantavirus
☐ Coxiella (Q-fever)
☐ Ehrlichia
☐ Rickettsia (RMSF and Typhus fever)
☐ Arbovirus Panel (WNV, SLE, EEE, WEE, CE)
☐ West Nile Virus
☐ Lacrosse Encephalitis
☐ St. Louis Encephalitis

SECTION 4. SYMPTOMS

☐ Symptomatic ☐ Asymptomatic ☐ Chronic ☐ Localized ☐ Disseminated

General Symptoms

☐ Fever _____°F
☐ Headache
☐ Sore Throat
☐ Cough
☐ Myalgia
☐ Anorexia
☐ Otitis
☐ Parotitis

Exanthema

☐ Maculopapular
☐ Papular
☐ Hemorrhagic
☐ Vesicular
☐ Petechial
☐ Erythema Migrans
☐ Oral Lesion
☐ Genital Lesion

CNS

☐ Encephalitis
☐ Meningitis
☐ Neck Rigidity
☐ Seizures
☐ Paralysis
☐ Chorea

Respiratory

☐ Common Cold
☐ ARDS
☐ Upper Resp. Inf.
☐ Lower Resp. Inf.
☐ Pneumonia
☐ Bronchitis
☐ Pharyngitis

G.I.

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Abdominal Pain
☐ Constipation
☐ Gastroenteritis

Ocular

☐ Conjunctivitis
☐ Chorioretinitis
☐ Blurred Vision

Cardiovascular

☐ Myocarditis
☐ Pericarditis
☐ Endocarditis
☐ Cardiomegaly

Organomegaly

☐ Splenomegaly
☐ Hepatomegaly
☐ Orchitis

Miscellaneous

☐ Jaundice
☐ Lymphadenopathy
☐ Pleurodynia

Other

_____
_____
_____
_____

SECTION 5. CONTACT / EXPOSURE

☐ Contact with and/or ☐ Exposure to: ☐ Human Cases ☐ Insects ☐ Animals ☐ Birds

Similar Infection: Family ☐ Yes ☐ No Community ☐ Yes ☐ No

COMPLETE REVERSE SIDE

SECTION 6. TRAVEL HISTORY *Travel history for the past 60 days:*

Traveled to / from _____

Date of Departure_____/_____/_____ **Date of Return**_____/_____/_____

SECTION 7. RELATED IMMUNIZATIONS

1. _____ Date_____/_____/_____
2. _____ Date_____/_____/_____
3. _____ Date_____/_____/_____

RECENT VACCINATIONS

1. _____ Date_____/_____/_____
2. _____ Date_____/_____/_____
3. _____ Date_____/_____/_____

SECTION 8. PROVIDER INFORMATION

_____
Healthcare Provider's Name

_____ _____-_____-_____ _____-_____-_____
E-mail Address **Phone Number** **Fax Number**

SECTION 9. SUBMITTER INFORMATION

_____ _____
Submitting Organization **Staff Name**

_____ _____ _____
Phone **Fax** **E-mail**

_____
Address

_____
Address

_____ _____ _____
City **State** **ZIP Code**

SPECIMEN COLLECTION

Submit at least 1ml of serum in a screw-capped serum tube. Alternatively collect at least 3ml for whole blood in a red top venipuncture or serum separator tube. Label the specimen tube with patient identifier and collection date. Specimens without a patient ID or collection date will be considered unsatisfactory and will not be tested.

Complete all sections 1 through 9 on this form in ink. Patient ID and collection date must match those recorded on the specimen tube. The submitter address to which the results are to be sent including zip code must be included as well as requested test type. Any incomplete information will cause significant delays in receiving results.

SPECIMEN PACKAGING AND SHIPMENT

Note: Specimens should be refrigerated at 4°C if held prior to shipping.

Serum or whole blood in serum separator tubes may be shipped at ambient temperature. Shipping whole blood in red top tubes at ambient temperature may result in hemolysis and a specimen unsatisfactory for testing.

1. **Use container 9A provided by ISDH. ISDH containers may be obtained by phoning (317) 921-5875.**
2. **Wrap the absorbent material, provided in the inner mailing container, around the specimen tube to absorb inner shock and contain possible leakage. Insert the wrapped specimen tube into the inner mailing container. Secure cap tightly. Place the completed requisition between the inner and outer mailing container and secure cap. Specimens should be shipped to arrive at ISDH Monday through Friday. Shipping specimens which will be in transit during the weekend or holiday is not recommended.**
3. **Complete the pre-addressed mailing label on the outer mailing container with a return address, leakage and breakage notification and postage, and send via first class US mail.**
4. **Please use the above packing instructions to assure compliance with federal shipping regulations and to minimize breakage. Broken or leaking specimens present a biohazard and cannot be tested.**
5. **Specimens submitted by courier should be packaged securely to prevent breakage. Loose specimens in zip lock bags increase the chance of breakage and biohazard exposure.**

DIRECT QUESTIONS TO: 317-921-5858

ISDH Lab Use Only

Date Received_____

Label