New York State Department of Health
Wadsworth Center
Empire State Plaza
PO Box 509, Albany, NY 12201-0509

Infectious Diseases Requisition

NYS Accession Number _____

Date received ____/____/____

Shipping address: www.wadsworth.org/wcinfo.htm

Telephone: (518) 474-4177

Patient Demographics

*denotes required information

Last Name * _____ First Name * _____ MI _____ DOB * ____/____/____ ☐ Male ☐ Female Sex

Street Address _____ City _____ State _____ Zip Code _____

NYS County of Residence * _____ NYS DOH Outbreak Number _____ CDESS Case Number _____ Submitter's Reference Number _____

Submitter (Laboratory report will be sent to)

*denotes required information

Name and Address *

Name Virology Laboratory - Clinical Pathology

Address SUNY Upstate Medical University
750 East Adams Street

City Syracuse State NY Zip 13210

Laboratory PFI 2220

Contact Person Elizabeth A. Palumbo

Telephone Number (315) 464 - 6740 ext. _____

Specimen Information

*denotes required information

Specimen is: ☐ Isolate ☐ Primary Specimen ☐ Autopsy Specimen

Collection Date * ____/____/____ (MM / DD / YYYY)

Source / Specimen Type * _____

Time Collected (if applicable for test) ____:____ (HH : MM)

Laboratory Examination Requested

www.wadsworth.org/IDtesting

☐ **Bacterial** ☐ **Fungal** ☐ **Mycobacterial** ☐ **Parasitic** ☐ **Serology** ☐ **Viral**

Suspected Organism / Agent _____

☐ **Identification / Confirmation**

☐ **TB Fast Track** www.wadsworth.org/mycobac/fasttrack.htm

☐ **Viral Encephalitis Panel** www.wadsworth.org/divisions/infdis/enceph/form.htm

☐ **Susceptibility (specify antimicrobial(s))** _____

☐ **Serology (specify test and define onset date)** _____

☐ **Other (specify)** _____

Submitting lab findings: Smear/Stain/Other results _____ Comments _____

Specimen submitted on/in: Media _____ Preservative _____ Tissue cell line _____

Relevant Exposure: ☐ Contact known case ☐ Food/water ☐ Nosocomial

☐ Travel _____ (Location & Dates) ☐ Animal _____ (Type) ☐ Arthropod _____ (Type)

Clinical History

Name of patient's healthcare provider _____ ( ) - ext. _____ (Telephone Number)

Diagnosis: _____ Hospitalized? ☐ Yes ☐ No ☐ Unknown If hospitalized, hospital name: _____

Pregnant (trimester): _____ Symptoms: ☐ Acute ☐ Chronic ☐ Other _____ Onset of symptoms: ____/____/____ (MM / DD / YYYY)

Fever: max _____ duration _____ CSF: Glu _____ Prot _____ RBC _____ WBC _____

Relevant Treatment: _____ Date ____/____/____ Relevant Immunization: _____ Date ____/____/____

Symptoms/Clinical Epidemiology (check all that apply):

Central Nervous System: ☐ Altered Mental Status ☐ Coma ☐ Encephalitis ☐ Headache ☐ Meningitis ☐ Paralysis ☐ Seizures

Gastrointestinal: ☐ Diarrhea ☐ Blood/Mucus ☐ Nausea ☐ Vomiting

Respiratory: ☐ Bronchitis ☐ Bronchiolitis ☐ Cough ☐ Pneumonia ☐ Upper Respiratory Infection

Skin/hair/nails: ☐ Hemorrhagic ☐ Maculopapular Rash ☐ Petechial Rash ☐ Vesicular

Cardiovascular: ☐ Endocarditis ☐ Myocarditis ☐ Pericarditis

Miscellaneous: ☐ Arthralgia ☐ Conjunctivitis ☐ Cystitis ☐ Hepatitis ☐ Hepatomegaly ☐ Immunocompromised ☐ Jaundice ☐ Keratitis ☐ Lymphadenopathy ☐ Malaise ☐ Myalgia ☐ Pleurodynia ☐ Splenomegaly ☐ Ulcer(s) ☐ Urethritis

Other Symptoms: _____