



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention (CDC)
National Center for Infectious Diseases
Atlanta, Georgia 30333



STUDY ID: _____	STATE CONTACT PERSON & PHONE NO.: _____	(for CDC Use Only)	DATE RECEIVED
		CDC LAB. CODE	Mo. Da. Yr.
		CDC NUMBER	Mo. Da. Yr.
<i>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*.</i> 1. Disease suspected to be of public health importance. Specimen is: (a) <input type="checkbox"/> from an outbreak. (b) <input type="checkbox"/> from uncommon or exotic disease. (c) <input type="checkbox"/> an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) <input type="checkbox"/> from a disease for which reliable diagnostic reagents or expertise are unavailable in State. 2. <input type="checkbox"/> Ongoing collaborative CDC/State project. 3. <input type="checkbox"/> Confirmation of results requested for quality assurance. *Prior arrangement for testing has been made. Please bring to the attention of: (name) _____		STATE HEALTH DEPT. NUMBER: _____ STATE LOC: _____	
		DATE SENT TO CDC: _____	
		PATIENT IDENTIFICATION NUMBER: _____	
		Have specimens from this patient been submitted previously <input type="checkbox"/> YES <input type="checkbox"/> NO	
		BIRTHDATE OR AGE _____	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
		RACE: White <input type="checkbox"/> Black <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Not Specific <input type="checkbox"/>	
		ETHNICITY: Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Not Specific <input type="checkbox"/>	
		CLINICAL DIAGNOSIS: _____	
		ASSOCIATED ILLNESS: _____	
		DATE OF ONSET: _____	FATAL? <input type="checkbox"/> YES <input type="checkbox"/> NO
LABORATORY EXAMINATION REQUESTED: <input type="checkbox"/> ANtimicrobial Susceptibility <input type="checkbox"/> IDentification <input type="checkbox"/> ISolation <input type="checkbox"/> HIstology <input type="checkbox"/> OTher (Specify) _____ <input type="checkbox"/> SErology (Specific Test) _____		CLINICAL TEST RESULTS: Sputum and Histological Findings: _____ Blood Counts: _____ Stool/Urine Exams: _____ Type Skin Tests Performed: Mo. Da. Yr. Strength Pos. Neg. _____	
CATEGORY OF AGENT SUSPECTED: <input type="checkbox"/> BActerial <input type="checkbox"/> VIral <input type="checkbox"/> FUngal <input type="checkbox"/> RIckettsial <input type="checkbox"/> PArasitic <input type="checkbox"/> OTher (Specify) _____			
SPECIFIC AGENT SUSPECTED: _____			
OTHER ORGANISM(S) FOUND: _____			
ISOLATION <input type="checkbox"/> YES <input type="checkbox"/> NO		NO. TIMES ISOLATED: _____	
SPECIMEN SUBMITTED IS: <input type="checkbox"/> Original Material <input type="checkbox"/> Pure Isolate <input type="checkbox"/> Mixed Isolate			
DATE SPECIMEN TAKEN: _____			
ORIGIN: <input type="checkbox"/> SOil <input type="checkbox"/> FOod <input type="checkbox"/> ANimal (Specify) _____ <input type="checkbox"/> HUman <input type="checkbox"/> OTher (Specify) _____			
SOURCE OF SPECIMEN: <input type="checkbox"/> BLood <input type="checkbox"/> SErum <input type="checkbox"/> CSF <input type="checkbox"/> STool <input type="checkbox"/> SPutum <input type="checkbox"/> URine <input type="checkbox"/> GAstic <input type="checkbox"/> HAir <input type="checkbox"/> SKin <input type="checkbox"/> THroat <input type="checkbox"/> WOund (Site) _____ <input type="checkbox"/> EXudate (Site) _____ <input type="checkbox"/> TIssue (Specify) _____ <input type="checkbox"/> OTher (Specify) _____		SIGN AND SYMPTOMS: <input type="checkbox"/> FEver Maximum Temperature: _____ Duration: _____ Days <input type="checkbox"/> CHills	
SUBMITTED ON: <input type="checkbox"/> EGg <input type="checkbox"/> TIssue Culture (Type) _____ <input type="checkbox"/> ANimal (Specify) _____ <input type="checkbox"/> MEidium (Specify) _____ <input type="checkbox"/> OTher (Specify) _____		CARDIOVASCULAR: <input type="checkbox"/> MYocarditis <input type="checkbox"/> PEricarditis <input type="checkbox"/> ENdocarditis <input type="checkbox"/> OTher _____	
SERUM INFORMATION: Mo. Da. Yr. _____ Mo. Da. Yr. _____ <input type="checkbox"/> ACute _____ <input type="checkbox"/> S3 _____		GASTROINTESTINAL: <input type="checkbox"/> DIarrhea <input type="checkbox"/> BLOOD <input type="checkbox"/> MUCous <input type="checkbox"/> CONSTipation <input type="checkbox"/> ABnormal Pain <input type="checkbox"/> VOmiting <input type="checkbox"/> OTher _____	
IMMUNIZATIONS: _____		MISCELLANEOUS: <input type="checkbox"/> JAundice <input type="checkbox"/> MYalgia <input type="checkbox"/> PLEurodynia <input type="checkbox"/> COnjunctivitis <input type="checkbox"/> CHorioretinitis <input type="checkbox"/> SPLeinomegaly <input type="checkbox"/> HEpatomegaly <input type="checkbox"/> LIVER Abscess/cyst <input type="checkbox"/> LYmphadenopathy <input type="checkbox"/> MUCous Membrane Lesions <input type="checkbox"/> OTher _____	
TREATMENT: Drugs Used: _____ DATE BEGUN Mo. Da. Yr. _____ DATE COMPLETED Mo. Da. Yr. _____		RESPIRATORY: <input type="checkbox"/> RHinitis <input type="checkbox"/> PUlmonary <input type="checkbox"/> PHaryngitis <input type="checkbox"/> CAlicifications <input type="checkbox"/> Otitis Media <input type="checkbox"/> PNeumonia (type) _____ <input type="checkbox"/> OTher _____	
		CENTRAL NERVOUS SYSTEM: <input type="checkbox"/> HEadache <input type="checkbox"/> MEningismus <input type="checkbox"/> MIcrocephalus <input type="checkbox"/> HYdrocephalus <input type="checkbox"/> SEizures <input type="checkbox"/> CErebral Calcification <input type="checkbox"/> CHorea <input type="checkbox"/> PAralysis Other _____	
		STATE OF ILLNESS: <input type="checkbox"/> SYmptomatic <input type="checkbox"/> ASymptomatic <input type="checkbox"/> SUBacute <input type="checkbox"/> CHronic <input type="checkbox"/> DIsseminated <input type="checkbox"/> LOcalized <input type="checkbox"/> EXtraintestinal <input type="checkbox"/> OTher _____	
		EPIDEMIOLOGICAL DATA: <input type="checkbox"/> Single Case <input type="checkbox"/> SPoradic <input type="checkbox"/> COntact <input type="checkbox"/> EPidemic <input type="checkbox"/> CArrier	
		Family Illness: _____ Community Illness: _____	
		Travel and Residence (Location): Mo. Da. Yr. <input type="checkbox"/> Foreign: _____ <input type="checkbox"/> USA: _____	
		Animal Contacts (Species): _____ Arthropod Contacts: <input type="checkbox"/> NONE <input type="checkbox"/> EXposure Only <input type="checkbox"/> BIte Type of Arthropod: _____ Suspected Source of Infection: _____	

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.

The types of specimens usually sent to CDC laboratories are serum specimens, reference cultures, or clinical specimens. To assist State health department laboratories and others in obtaining the information on the request form that NCID requires, the following tabulation for each of the 3 types of specimens should serve as a guide.

SERUM SPECIMENS

Required

Laboratory exam requested
Specific agent suspected
Serum information*
Immunization*
Treatment*
Epidemiologic data*
Previous lab results

Useful

Clinical information
Signs, symptoms, etc.

REFERENCE CULTURES

Required

Laboratory exam requested
Category of agent suspected
Specific agent suspected
Kind of specimen
Origin of specimen
Source of specimen
Submitted on what medium
Previous lab results
Biochemical reaction (can be attached on a separate sheet)

Useful

Isolation attempted
Date specimen taken
Number times isolated
Other clinical information
Clinical test results
Signs, symptoms, etc.
Other organisms found**
Epidemiologic data*
Treatment*

CLINICAL SPECIMENS

Required

Laboratory exam requested
Category of agent suspected
Specific agent suspected
Specimen submitted is
Date specimen taken
Source of specimen
Epidemiologic data*
Previous lab results

Useful

Other clinical information
Clinical test results
Signs, symptoms, etc.

The Reference and Disease Surveillance Booklet should be consulted for special requirement.

**Exercise good judgement to determine the relevance of these items.* Paired sera are required for viral and bacterial disease serology, a single serum is required for mycotic and parasitic diseases and for syphilis serology (congenital syphilis excepted). In all instances the date(s) of collection of serum specimens must be provided. Immunization history is required when such information relates to the serology requested, i.e., required for polio, measles, etc., not required for histoplasmosis, echinococcosis, etc. Information on treatment, such as administration of immune serum or globulin, antibiotics, etc., is often of great benefit when doing serology or identifying reference cultures. As much relevant epidemiologic data as can be obtained should be provided. History of travel and animal or arthropod contacts are required for those RDS in which this kind of information is clearly necessary. If any required item of information is not available after efforts have been made to obtain it, please so indicate.

***Bacterial cultures representing growth of a single or a few colonies on the same primary isolation agar plates from which the principal pathogen has been isolated and identified should not be submitted for identification unless clinical findings or other justification support such submissions.*