LABORATORY EXAMINATION(S) REQUESTED:				CATEGORY OF AGENT SUSPECTED:			
ANtimicrobial ISolation			☐ BActerial ☐ RIckettsial				
Susceptibility SErology (Specific Test) HIstology			☐ VIral ☐ PArasitic				
☐ IDentification ☐ OTher (Specify)			☐ FU ngal	OTher (Specify)			
SPECIFIC AGENT SUSPECTED:	OTHER ORGANISM(S) FOUND:	ISOLATION ATTEMPTED?	NO. OF TIMES	NO. OF TIMES PASSED:		JBMITTED IS:	
			ISOLATED:	PASSED:	☐ Original Ma	aterial Mixed Isolate	
		YES NO			Pure Isolat	э 	
DATE SPECIMEN TAKEN:	ORIGIN:						
//YB	HUman Soil (Specify) (Specify)						
SOURCE OF SPECIMEN:	SUBMITTED ON:						
BLood CSF WOund (Site)				MEdium			
GAstric HAir EXudate (Site)			☐ ANimal				
SErum SKin			☐ Tissue Culture (Type)				
SPutum STool Tissue (Specify)							
	pecify)		☐ EGg ☐ OTher (Specify)				
SERUM INFORMATION: MO DA YE	MO DA YR	SiGn	IS AND SYMPTON	MS:		VOUS SYSTEM:	
MO DA YR S3// [ACute// S4//			FEver Maximum Temper	rature:	☐ HEadache ☐ MEningismus		
Convalescent//			Duration:Days		Microcephalus		
				CHills		☐ HYdrocephalus☐ SEizures	
		SKIN	l :		CErebral Calcification		
] MAculopapular] HEmorrhagic		☐ CHorea☐ PAralysis		
			VE sicular		☐ OTher		
(3.)			Erythema Nodosum Erythema Marginatum		MISCELLANEOUS:		
			OTher		☐ JAundice ☐ MYalgia ☐ PLeurodynia		
TREATMENT: DRUGS USED None DATE BEGUN DATE COMPLETED MO DA YR MO DA YR R							
(1)			RHinitis		COnjunctivi	itis	
			PUlmonary PHaryngitis		☐ CHorioretinitis☐ SPlenomegaly		
			CAlcifications		☐ HE patome	☐ HE patomegaly	
(3.)			Otitis Media PNeumonia (type)		Liver Absce		
EPIDEMIOLOGICAL DATA:			OTher		☐ LYmphadenopathy☐ MUcous Membrane Lesions		
☐ SIngle Case ☐ SPoradic ☐ C	COntact	CAB	DIOVASCULAR:		☐ OT her		
Family Illnoce			MYocarditis		STATE OF ILLNESS:		
Continuity liness			☐ PEricarditis ☐ ENdocarditis		☐ SYmptomatic☐ ASymptomatic		
Travel and Residence (Location)			☐ OTher		☐ SUbacute		
☐ Foreign			ASTROINTESTINAL:		☐ CHronic☐ Disseminated		
☐ USA			■ Dlarrhea		LOcalized		
Animal Contacts (Species)			☐ BLood ☐ MUcous		☐ EXtraintestinal ☐ OTher		
Anthropod Contacts: ☐ None ☐ Exposuer Only ☐ Bite			☐ CO nstipation				
Type of Anthropod:			ABnormal Pain VOmiting				
Suspected Source of Infection:			OTher				
•	THER CLINICAL INFORMATION: (Information)	ation supplied should	I be related to this o	assa and/or specim	on(c) and rolativo	to the test(s) requested	
PREVIOUS EABORATORT RESULTS/O	THE CLINICAL INFORMATION. (IIIIOTHE	ation supplied should	The related to triis t	case and/or specim	eri(s) and relative	to the test(s) requested.	
ODO 50.04 Dec. 00/0000 /7:000	ODO ODEOMEN OUDWOODS TO THE		UNIT	FY	NUMBER	SUF.	
CDC 50.34 Rev. 09/2002 (BACK)	- CDC SPECIMEN SUBMISSION FORM	CDC NU		1 1	INUIVIDEN	OUF.	

luctification must be completed by State health department laborate	ony hafora spaciman can ha accepted by	STATE HEALTH DEPARTMENT LABORATORY ADDR	FSS:			
Justification must be completed by State health department laborate CDC. Please check the <u>first</u> applicable statement and when appropriate Disease suspected to be of public health importance. Specimer						
(a) \square from an outbreak. (b) \square from uncommon or exotic disea	se.					
(c) ☐ an isolate that cannot be identified, is atypical, shows mul normally sterile site(s)(d) ☐ from a disease for which re						
are unavailable in State. 2. Ongoing collaborative CDC/State project.	Completed by:	†				
3. Confirmation of results requested for quality assurance.						
*Prior arrangement for testing has been made. Please bring to the attention of:		STATE HEALTH DEPT. NO.: DATE SENT TO CDC:				
(Name):	Date://	PATIENT IDENTIFICATION: (Hospital No.)	(MM/DD/YYYY)//			
Name, Address and Phone Number of Physician or Or	ganization:	` ' '				
		NAME: (LAST, FIRST, MI)				
		BIRTHDATE: (MM/DD/YYYY) / /	SEX: MALE FEMALE			
		CLINICAL				
		DIAGNOSIS:				
(FOR CDC USE ONLY) CDC NUMBER UNIT FY NUMBER	SUF DATE RECEIVED NO DA YR	ASSOCIATED ILLNESS:				
	MIO DA III	DATE OF ONSET:	FATAL? YES NO			
	REVERSE SIDE OF THIS F	ORM MUST BE COMPLETED				
	THIS FORM MUST BE EI	THER PRINTED OR TYPED				
PLEA	SE PREPARE A SEPARA	TE FORM FOR EACH SPECIMEN				
	D.A.S.H.					
	217 11.011 11					
		DATE REPORTED				
		MO DA YR				
	0 3					
	Comments:					
		D 6 5				
STANT SERVICES CO.	DEPARTMENT OF HEALT	TH AND HUMAN SERVICES				
		alth Service				
i i i i i i i i i i i i i i i i i i i		Disease Control				



nter for Infectious Diseas Atlanta, Georgia 30333



The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.