CDC Specimen Submission Form

LABORATORY EXAMINATION(S) REQUESTED:

- ☐ ANtimicrobial Susceptibility
- ☐ ISolation
- ☐ HIstology
- ☐ SErology (Specific Test) _____
- ☐ IDentification
- ☐ OTher (Specify) _____

CATEGORY OF AGENT SUSPECTED:

- ☐ BActerial
- ☐ RIckettsial
- ☐ VIral
- ☐ PArasitic
- ☐ FUngal
- ☐ OTher (Specify) _____

SPECIFIC AGENT SUSPECTED:	OTHER ORGANISM(S) FOUND:	ISOLATION ATTEMPTED?	NO. OF TIMES ISOLATED:	NO. OF TIMES PASSED:	SPECIMEN SUBMITTED IS:
		☐ YES ☐ NO			☐ Original Material ☐ Mixed Isolate ☐ Pure Isolate

DATE SPECIMEN TAKEN:

__/__/__ (MO DA YR)

ORIGIN:

- ☐ FOod
- ☐ ANimal (Specify) _____
- ☐ OTher (Specify) _____
- ☐ HUman
- ☐ SOil

SOURCE OF SPECIMEN:

- ☐ BLood
- ☐ CSF
- ☐ GAstric
- ☐ HAir
- ☐ SErum
- ☐ SKin
- ☐ SPutum
- ☐ STool
- ☐ URine
- ☐ THroat
- ☐ WOund (Site) _____
- ☐ EXudate (Site) _____
- ☐ TIssue (Specify) _____
- ☐ OTher (Specify) _____

SUBMITTED ON:

- ☐ MEdium _____
- ☐ ANimal _____
- ☐ TIssue Culture (Type) _____
- ☐ EGg
- ☐ OTher (Specify) _____

SERUM INFORMATION:

	MO DA YR		MO DA YR
☐ ACute	__/__/__	☐ S3	__/__/__
☐ CONvalescent	__/__/__	☐ S4	__/__/__
		☐ S5	__/__/__

IMMUNIZATIONS:

	MO YR
(1.) _____	__/__
(2.) _____	__/__
(3.) _____	__/__
(4.) _____	__/__

TREATMENT: DRUGS USED ☐ None

	DATE BEGUN (MO DA YR)	DATE COMPLETED (MO DA YR)
(1.) _____	__/__/__	__/__/__
(2.) _____	__/__/__	__/__/__
(3.) _____	__/__/__	__/__/__

EPIDEMIOLOGICAL DATA:

☐ SIngle Case ☐ SPoradic ☐ CONtact ☐ EPidemic ☐ CArrier

Family Illness _____

Community Illness _____

Travel and Residence (Location)

- ☐ Foreign _____
- ☐ USA _____

Animal Contacts (Species) _____

Anthropod Contacts: ☐ None ☐ Exposuer Only ☐ Bite

Type of Anthropod: _____

Suspected Source of Infection: _____

SIGNS AND SYMPTOMS:

- ☐ FEver
  - Maximum Temperature: _____
  - Duration: _____ Days
- ☐ CHills

SKIN:

- ☐ MAculopapular
- ☐ HEmorrhagic
- ☐ VEsicular
- ☐ Erythema Nodosum
- ☐ Erythema Marginatum
- ☐ OTher

RESPIRATORY:

- ☐ RHinitis
- ☐ PUlmonary
- ☐ PHaryngitis
- ☐ CAlcifications
- ☐ Otitis Media
- ☐ PNeumonia (type)
- ☐ OTher

CARDIOVASCULAR:

- ☐ MYocarditis
- ☐ PEricarditis
- ☐ ENdocarditis
- ☐ OTher

GASTROINTESTINAL:

- ☐ DIarrhea
  - ☐ BLood
  - ☐ MUcous
- ☐ CONstipation
- ☐ ABnormal Pain
- ☐ VOmiting
- ☐ OTher

CENTRAL NERVOUS SYSTEM:

- ☐ HEadache
- ☐ MEningismus
- ☐ MIcrocephalus
- ☐ HYdrocephalus
- ☐ SEizures
- ☐ CErebral Calcification
- ☐ CHorea
- ☐ PAralysis
- ☐ OTher

MISCELLANEOUS:

- ☐ JAundice
- ☐ MYalgia
- ☐ PLeurodynia
- ☐ CONjunctivitis
- ☐ CHorioretinitis
- ☐ SPlenomegaly
- ☐ HEpatomegaly
- ☐ LIver Abscess/cyst
- ☐ LYmphadenopathy
- ☐ MUcous Membrane Lesions
- ☐ OTher

STATE OF ILLNESS:

- ☐ SYmptomatic
- ☐ ASymptomatic
- ☐ SUbacute
- ☐ CHronic
- ☐ DISseminated
- ☐ LOcalized
- ☐ EXtraintestinal
- ☐ OTher

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.

CS106190

CDC NUMBER	UNIT	FY	NUMBER	SUF.

Justification must be completed by State health department laboratory before specimen can be accepted b CDC. Please check the first applicable statement and when appropriate complete the statement with the ⋆.

1. Disease suspected to be of public health importance. Specimen is:
   (a) ❑ from an outbreak. (b) ❑ from uncommon or exotic disease.
   (c) ❑ an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) ❑ from a disease for which reliable diagnostic reagents or expertise are unavailable in State.
2. ❑ Ongoing collaborative CDC/State project.
3. ❑ Confirmation of results requested for quality assurance.

⋆Prior arrangement for testing has been made.
Please bring to the attention of:

(Name): _____

Completed by:

_____

Date: __ __/__ __/__ __ __ __

Name, Address and Phone Number of Physician or Organization:

STATE HEALTH DEPARTMENT LABORATORY ADDRESS:

STATE HEALTH DEPT. NO.: _____

DATE SENT TO CDC: (MM/DD/YYYY) __ __/__ __/__ __ __ __

PATIENT IDENTIFICATION: (Hospital No.) _____

NAME: (LAST, FIRST, MI) _____

BIRTHDATE: (MM/DD/YYYY) __ __/__ __/__ __ __ __

SEX: ❑ MALE ❑ FEMALE

CLINICAL DIAGNOSIS: _____

ASSOCIATED ILLNESS: _____

DATE OF ONSET: (MM/DD/YYYY) __ __/__ __/__ __ __ __

FATAL? ❑ YES ❑ NO

UNIT	FY	NUMBER	SUF	DATE RECEIVED MO DA YR
				__ __/__ __/__ __ __ __

THIS FORM MUST BE EITHER PRINTED OR TYPED
PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN

D.A.S.H.

DATE REPORTED
MO DA YR
___ ___/___ ___/___ ___ ___ ___

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Comments:

D	6	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Center for Infectious Diseases
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.