

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 * ____ / ____ / ____ Sex Male Female

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 * _____ Laboratory PFI _____

Name _____ Address _____ Contact Person _____

City _____ State _____ Zip _____ Telephone Number (____) _____ - _____ 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 Susceptibility (specify antimicrobial(s)) _____

TB Fast Track www.wadsworth.org/mycobac/fasttrack.htm Serology (specify test and define onset date) _____

Viral Encephalitis Panel Other (specify) _____
www.wadsworth.org/divisions/infdis/enceph/form.htm

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 _____ Animal _____ Arthropod _____
Location & Dates Type Type

Clinical History

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

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: _____