

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- | | |
|---|--|
| <input type="checkbox"/> BAL / Bronchial Washing | <input type="checkbox"/> CSF |
| <input type="checkbox"/> Bronchial brush | <input type="checkbox"/> Genital swab |
| <input type="checkbox"/> Combined throat / nasal swabs | <input type="checkbox"/> Lesion swab |
| <input type="checkbox"/> Nasal wash / aspirate | <input type="checkbox"/> Ocular swab |
| <input type="checkbox"/> Nasopharyngeal swab | <input type="checkbox"/> Tear strip |
| <input type="checkbox"/> Nasopharyngeal wash / aspirate | <input type="checkbox"/> Peritoneal fluid |
| <input type="checkbox"/> Oral buccal | <input type="checkbox"/> Pericardial fluid |
| <input type="checkbox"/> Sputum | <input type="checkbox"/> Pleural fluid |
| <input type="checkbox"/> Throat swab | <input type="checkbox"/> Synovial fluid |
| <input type="checkbox"/> Throat wash | <input type="checkbox"/> Rectal swab |
| <input type="checkbox"/> Tracheal aspirate | <input type="checkbox"/> Stool |
| | <input type="checkbox"/> Stool (ETM) |

Other: _____

DATE COLLECTED: ____ / ____ / ____
mm / dd / year

PATIENT: _____

BIRTH DATE: ____ / ____ / ____
mm / dd / year

SSN #: ____ - ____ - ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: ____

PHONE: (____) ____ - ____

GENDER: Female Male

RACE: White Black Asian American Indian / Alaskan Native
 Native Hawaiian / Pacific Islander Unknown

ETHNICITY: Hispanic Non Hispanic Unknown

PATIENT ID #: _____

CLINICIAN: _____ CLINICIAN ID #: _____
please print last first

PHONE: (____) ____ - ____ CLINICIAN'S Signature: _____

As the clinician providing care to this patient, I request that this test be performed without charge to this patient because of the imminent and significant public health threat posed by the differential diagnosis.

Test(s) Requested

Check all that apply

Culture / DFA

(swabs must be in viral transport medium)

- Virus Isolation/Detection and Identification
 Herpes Simplex Virus (dermal/genital)
 Varicella Zoster Virus (dermal)

PCR

- Influenza
 Confirm Rapid Assay
 Herpes Simplex Virus (CSF or ocular)
 Enterovirus (CSF)
 Norovirus (stool)
 Mumps
 Bordetella pertussis
 Mycoplasma pneumoniae
 Legionella pneumophila
 Chlamydomphila (Chlamydia) pneumoniae

Patient History

Clinical Diagnosis: _____

Date of Onset: ____ / ____ / ____
mm / dd / year

Fever: _____ °F (in office)

Signs & Symptoms

- Cough
 Duration _____ days
- Conjunctivitis
 Headache
 Photophobia
 Myalgia
 Pharyngitis
 Vesicular Rash / Lesion
 Maculopapular Rash
 Meningitis / Encephalitis
 Myocarditis / Pericarditis
 Diarrhea

International Travel: ____ / ____ / ____
mm / dd / year

Influenza Vaccination: ____ / ____ / ____
mm / dd / year

- Live (FluMist)
 Killed (Injection)

Started Antibiotic / Antiviral: ____ / ____ / ____
mm / dd / year

Type: _____

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____

Insured's ID#: _____
please print

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____



Enter your facility address
Results are returned
to this address

Viral Detection &
Viral and Bacterial PCR
Test Request Form

University Hygienic Laboratory

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Iowa City, IA 52242-5002
Phone #: 319-335-4500
Fax #: 319-335-4555
<http://www.uhi.uiowa.edu>