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

- ☐ BAL / Bronchial Washing
- ☐ Bronchial brush
- ☐ Cervical Swab
- ☐ Combined throat / nasal swabs
- ☐ Nasal Swab
- ☐ Nasal wash / aspirate
- ☐ Nasopharyngeal swab
- ☐ Nasopharyngeal wash / aspirate
- ☐ Buccal swab
- ☐ Sputum
- ☐ Throat swab
- ☐ Throat wash
- ☐ Tracheal aspirate
- ☐ Ocular / Conjunctiva swab
- ☐ CSF
- ☐ Genital swab
- ☐ Lesion swab
- ☐ Tear strip
- ☐ Peritoneal fluid
- ☐ Pericardial fluid
- ☐ Pleural fluid
- ☐ Rectal Mucosa
- ☐ Rectal swab
- ☐ Stool
- ☐ Stool (ETM)
- ☐ Tissue / Biopsy
- ☐ Urethral Swab

☐ Other: _____

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

PATIENT: _____ (last) _____ (first)

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

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.

Viral and Chlamhydial Detection & Viral and Bacterial PCR Test Request Form

Test(s) Requested

Check all that apply

Culture / DFA

- ☐ Virus Isolation/Detection and Identification
- ☐ Herpes Simplex Virus (dermal/genital)
- ☐ Varicella Zoster Virus (dermal)
- ☐ *Chlamydia trachomatis*
- ☐ Cytomegalovirus (CMV)
- ☐ Respiratory Syncytial Virus (RSV)

PCR

- ☐ Influenza (includes seasonal H1 & H3 and Novel H1N1)
  - ☐ Confirm Rapid Assay Positive
- ☐ Herpes Simplex Virus (CSF or ocular)
- ☐ Enterovirus (CSF)
- ☐ Norovirus (stool)
- ☐ Mumps
- ☐ *Bordetella pertussis*
- ☐ *Mycoplasma pneumoniae*
- ☐ *Legionella pneumophila*
- ☐ *Chlamydophila (Chlamydia) pneumoniae*

Patient History

Clinical Diagnosis: _____

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

☐ Hospitalized (in-patient)

Signs & Symptoms

- ☐ Fever
- ☐ Influenza Like Illness
- ☐ Cough
  - Duration _____ days
- ☐ Myalgia
- ☐ Headache
- ☐ Pharyngitis
- ☐ Conjunctivitis
- ☐ Meningitis / Encephalitis
- ☐ 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: _____ (please print)

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ___ Zip: _____

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

Facility Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Enter your facility address
Results are returned
to this address