

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: Courier Address: 5668 State Farm Rd, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to:
<https://www.wadsworth.org/programs/id>

Patient Demographics and Requesting Provider *required information

Last name*	First name*	MI	DOB*	<input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female
Permanent Street Address	Facility of Residence (if applicable)	City	State	Zip Code
NYS County of Residence*	Patient Reference Number	NYS DOH Outbreak Number	CDESS Case Number	
*Race (Select one or more) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White				
*Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino				

Name and National Provider Identifier (NPI) for Health Care Provider: _____ Phone: () -

Submitting Facility (Laboratory report will be sent to this address) *required information

Name*	Laboratory PFI
Address*	NPI
Contact Person*	Phone* () -

Specimen Information *required information

Collection Date*: / /	Time Collected (if applicable):	Date of Symptoms Onset: / /	<input type="checkbox"/> Autopsy
Source(s)*	Specimen submitted on/in (specify media/preservative/cell line)	Submitter's Specimen Identifier(s)	
	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		
	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		
	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		

Laboratory Examination Requested

<input type="checkbox"/> Confirmation <input type="checkbox"/> Identification/Detection		Submitter Lab Findings: Smear/Stain/Other: _____
Suspect Organism/Agent		Suspect Organism/Agent
<input type="checkbox"/> Bacterial	<input type="checkbox"/> Parasitic	
<input type="checkbox"/> Antimicrobial Resistance Laboratory Network Susceptibility	<input type="checkbox"/> Malaria Drug Susceptibility	
<input type="checkbox"/> Other Susceptibility (please specify): _____	<input type="checkbox"/> Serology	
<input type="checkbox"/> Fungal	<input type="checkbox"/> Viral**	
<input type="checkbox"/> Antimicrobial Resistance Laboratory Network Susceptibility	<input type="checkbox"/> Viral Encephalitis PCR Panel on CSF	
<input type="checkbox"/> Other Antifungal Susceptibility	<input type="checkbox"/> Influenza Antiviral Susceptibility	
<input type="checkbox"/> Mycobacterial	<input type="checkbox"/> Other	

Clinical History

<input type="checkbox"/> Health Care Worker <input type="checkbox"/> Donor Screening	Relevant Exposure: <input type="checkbox"/> Travel <input type="checkbox"/> Animal <input type="checkbox"/> Arthropod <input type="checkbox"/> Contact w/ Known Case <input type="checkbox"/> Food/Water
Exposure Detail: _____	Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Name: _____
Diagnosis: _____	Pregnant (trimester): _____ Fever (max): _____ CSF: Glu _____ Prot _____ RBC _____ WBC _____
Relevant Treatment: _____	Date: / / Relevant Immunization: _____ Date: / /
**Symptoms (check all applicable): <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Other Symptoms _____	

Cardiovascular	Central Nervous System	Rash	Respiratory	Miscellaneous	
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Altered Mental Status	<input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Lymphadenopathy
<input type="checkbox"/> Myocarditis	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Maculopapular	<input type="checkbox"/> Cough	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Malaise
<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Headache	<input type="checkbox"/> Petechial	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Myalgia
	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Vesicular	<input type="checkbox"/> Upper Respiratory	<input type="checkbox"/> Hepatomegaly	<input type="checkbox"/> Splenomegaly
	<input type="checkbox"/> Paralysis			<input type="checkbox"/> Immunocompromised	

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Submitter (test ordered by) *required information

Name*: _____
Address*: _____
Contact Person*: _____ Phone*: () -

Sample Information

Collection Date*: / / Rabies Lab Only Second Collection Date: / /
NYSDOH Outbreak Number: _____
Collection Site: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____ NYS County: _____

Laboratory Examination Requested

Bacterial Fungal Mycobacterial Parasitic Serology Viral Other
Suspect Organism/Agent: _____

Animal

Domestic Wild
 Avian Mammal Reptile Other
Common Name or Species: _____
Submitter Sample Number: _____ Sample Source: _____
Domestic Animal Owner Name: _____ Animal Name: _____
Comments: _____

Food

Brand Name: _____
Lot Number: _____ USDA Number: _____ Sell By Date: / /
Sample Description: _____
Comments: _____

Environmental

Source Description: _____
Describe below samples taken; use separate sheets if necessary.

Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)	Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)

Comments: _____