

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability Accountability Act."

Lab 275 (Rev 8/2009)

KY Division of Laboratory Services

**Viral Isolation
and
Immunology**

100 Sower Blvd Suite 204
Frankfort KY 40601
(502) 564-4446 FAX (502) 564-7019

Stephanie K. Mayfield Gibson, MD, FCAP, Director

Patient Information:

(can use label here with complete info)

Name (Last, First, MI)

Social Security # Sex EO Age (dd-mmm-yyyy)

Home Address

City

State ZIP County

Send Reports to:

Submitter

Street Address / P O Box

City

State ZIP

Phone Fax

Physician (if other than Submitter)

Tests Requested

Viral Isolation: Specimen Type / Date Collected

Influenza Throat Swab _____
 Hospitalization NP Swab _____
 Institutionalized Nasal Swab _____
 Pregnant (___ weeks) Genital Swab _____
 Herpes CSF _____
 Enterovirus Other _____
 Other _____

Agent Detection: Date Collected

B. Pertussis FA Slide _____
 Herpes virus FA Slide _____

Serology: Date Collected

Serum

Toxoplasmosis _____
 CMV _____
 Herpes _____
 Measles (Rubeola) _____
 Varicella zoster _____
 Mumps _____
 ARBOVIRUSES: _____
 West Nile Serum _____
 Other CSF _____

PCR Date Collected

NOROVIRUS Stool _____
 Other _____
 Other, Specify: _____ Serum _____

CLINICAL DATA

Purpose of request:

diagnostic (give onset)
 immune status
 antibody status
 Other _____

Date of Onset:

Symptoms: YES NO

Fever
 Neurological
 Headache
 Respiratory
 Gastrointestinal
 Fatigue
 Rash
 Lesions
 Other _____

Immunizations / Date

None
 MMR _____
 Influenza _____
 Varicella _____
 Other _____

Contacts / Recent Travel

Tick bite _____
 Mosquito bite _____
 Community _____
 Other _____
 Travel _____

***** DLS Laboratory Findings*****

Date Received	Laboratory #	Tech	Date Reported