

Lab Test Request Form

Virology

(*) INDICATES REQUIRED INFORMATION. INCOMPLETE INFORMATION MAY CAUSE SPECIMEN REJECTION.

Patient Information		Submitter Information	
*First Name	*Last Name	*Facility Name	
*Date of Birth	*Gender	*Facility Address	
Patient's Home Address		*City, State	*Zip Code
City, State	Parish	Name of Contact Person	
Medicaid Number	Patient ID Number	Phone ()	Fax ()

Specimen Information

Submitted Specimen Is From: Human Animal _____

***Collection** Date: Time: **If Frozen, indicate** Date: Time:

***Specimen Type:** Swab Aspirate/Wash Tissue Viral Culture

***Specimen Source:** Nasal Nasopharynx CSF Blood
 Oropharynx Bronchii Acute Serum Stool
 Other Trachea Convalescent Serum Vomitus

Additional Information: Mother Follow-Up **Date of Symptom Onset:** _____
 Child Prenatal

Test Request Information

All tests listed may not currently be available. For questions regarding test availability, contact the Virology Dept. at 504-219-4676.

***At Least One Test Must Be Requested**

<input type="checkbox"/> Respiratory Virus Panel RSV, Influenza, Parainfluenza Metapneumovirus, Rhinovirus and Adenovirus	<input type="checkbox"/> Arbovirus Panel, IFA SLE IgM, SLE IgG, EEE, IgM, EEE IgG, CE IgM, CE IgG, WEE IgM and WEE IgG	<input type="checkbox"/> Hepatitis A Hepatitis A Total Antibody (Anti-HAV) Hepatitis A IgM Antibody (Anti-HAV IgM)
<input type="checkbox"/> Norovirus Real Time RT-PCR Norovirus GI and GII	<input type="checkbox"/> Arbovirus Panel, MIA West Nile and SLE	<input type="checkbox"/> Hepatitis B Panel Hepatitis B Surface Antigen (HBsAg) Hepatitis B Core Total Antibody (Anti-HBc)
<input type="checkbox"/> Influenza Real Time RT-PCR Detection and Characterization	<input type="checkbox"/> Maternal Serum Panel HCG, uE3, AFP and Inhibin A	<input type="checkbox"/> Hepatitis B Immunization (Anti-HBs) <input type="checkbox"/> Hepatitis B Core IgM Antibody (Anti-HBc IgM) <input type="checkbox"/> Hepatitis C Total Antibody (Anti-HCV)

Epi Risk Factor _____

Other Testing

<input type="checkbox"/> Herpes IgM <input type="checkbox"/> Herpes IgG <input type="checkbox"/> Lyme IgM <input type="checkbox"/> Lyme IgG <input type="checkbox"/> Lyme Total Aby	<input type="checkbox"/> Rubella IgG <input type="checkbox"/> Toxo IgG <input type="checkbox"/> CMV IgG <input type="checkbox"/> Measles IgM <input type="checkbox"/> Measles IgG	<input type="checkbox"/> Mumps IgG <input type="checkbox"/> Vaccinia <input type="checkbox"/> Varicella <input type="checkbox"/> Other
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To Be Forwarded to CDC: Yes **Diagnosis Suspected:** _____
 Contact 504-219-4646 for prior approval. Please include One CDC History form per specimen.

Send To: DHH-OPH Central Lab, 3101 West Napoleon Ave., Metairie, LA 70001

TO BE COMPLETED BY STATE LABORATORY

LABORATORY NUMBER:

DATE/TIME RECEIVED:

TEMPERATURE CONDITION: