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

- ☐ BAL / Bronchial Washing
- ☐ Bronchial brush
- ☐ Combined throat / nasal swabs
- ☐ Nasal wash / aspirate
- ☐ Nasopharyngeal swab
- ☐ Nasopharyngeal wash / aspirate
- ☐ Oral buccal
- ☐ Sputum
- ☐ Throat swab
- ☐ Throat wash
- ☐ Tracheal aspirate
- ☐ CSF
- ☐ Genital swab
- ☐ Lesion swab
- ☐ Ocular swab
- ☐ Tear strip
- ☐ Peritoneal fluid
- ☐ Pericardial fluid
- ☐ Pleural fluid
- ☐ Synovial fluid
- ☐ Rectal swab
- ☐ Stool
- ☐ Stool (ETM)
- ☐ 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 Detection & Viral and Bacterial PCR Test Request Form

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*
- ☐ *Chlamydophila (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: _____ (please print)

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ___ Zip: _____

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102 Oakdale Campus, #101 OH
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Fax #: 319-335-4555
http://www.uhl.uiowa.edu

Facility Name: IOWA METHODIST MEDICAL CENTER (132)
SEND OUT AREA

Address: 1200 PLEASANT

City: DES MOINES State: IA Zip: 50309-

Results are returned to this address