Lab Form 96
Revision 12/2009

Lab Test Request Form
Virology

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

Patient Information

*First Name _____ *Last Name _____

*Date of Birth _____ *Gender _____

Patient's Home Address _____

City, State _____ Parish _____

Medicaid Number _____ Patient ID Number _____

Submitter Information

*Facility Name _____

*Facility Address _____

*City, State _____ *Zip Code _____

Name of Contact Person _____

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 ☐ Oropharynx ☐ Other _____
☐ Nasopharynx ☐ Bronchii ☐ Trachea
☐ CSF ☐ Acute Serum ☐ Convalescent Serum
☐ Blood ☐ Stool ☐ Vomitus

Additional Information: ☐ Mother ☐ Child ☐ Follow-Up ☐ Prenatal

Date of Symptom Onset: _____

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

☐ **Respiratory Virus Panel**
RSV, Influenza, Parainfluenza Metapneumovirus, Rhinovirus and Adenovirus

☐ **Norovirus Real Time RT-PCR**
Norovirus GI and GII

☐ **Influenza Real Time RT-PCR**
Detection and Characterization

☐ **Arbovirus Panel, IFA**
SLE IgM, SLE IgG, EEE, IgM, EEE IgG, CE IgM, CE IgG, WEE IgM and WEE IgG

☐ **Arbovirus Panel, MIA**
West Nile and SLE

☐ **Maternal Serum Panel**
HCG, uE3, AFP and Inhibin A

Hepatitis A
☐ Hepatitis A Total Antibody (Anti-HAV)
☐ Hepatitis A IgM Antibody (Anti-HAV IgM)

☐ **Hepatitis B Panel**
Hepatitis B Surface Antigen (HBsAg)
Hepatitis B Core Total Antibody (Anti-HBc)

☐ **Hepatitis B Immunization (Anti-HBs)**

☐ **Hepatitis B Core IgM Antibody (Anti-HBc IgM)**

☐ **Hepatitis C Total Antibody (Anti-HCV)**

Epi Risk Factor _____

Other Testing
☐ Herpes IgM ☐ Herpes IgG ☐ Lyme IgM ☐ Lyme IgG ☐ Lyme Total Aby
☐ Rubella IgG ☐ Toxo IgG ☐ CMV IgG ☐ Measles IgM ☐ Measles IgG
☐ Mumps IgG ☐ Vaccinia ☐ Varicella ☐ Other _____

To Be Forwarded to CDC: ☐ Yes
Contact 504-219-4646 for prior approval.

Diagnosis Suspected: _____
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:**