

Patient Information		Submitter Information	
*First Name _____	*Last Name _____	*Facility Name _____	
*Date of Birth _____		*Gender _____	
Patient's Home Address _____		*Facility Address _____	
City, State _____		*City, State _____	*Zip Code _____
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	☐ Oropharynx	☐ Other	☐ Nasopharynx
☐	☐	☐	☐ Bronchii
☐	☐	☐	☐ Trachea
☐	☐	☐	☐ CSF
☐	☐	☐	☐ Acute Serum
☐	☐	☐	☐ Convalescent Serum
☐	☐	☐	☐ Blood
☐	☐	☐	☐ Stool
☐	☐	☐	☐ 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			
☐ Respiratory Virus Panel RSV, Influenza, Parainfluenza Metapneumovirus, Rhinovirus and Adenovirus	☐ Arbovirus Panel, IFA SLE IgM, SLE IgG, EEE, IgM, EEE IgG, CE IgM, CE IgG, WEE IgM and WEE IgG	☐ Hepatitis A Hepatitis A Total Antibody (Anti-HAV) ☐ Hepatitis A IgM Antibody (Anti-HAV IgM)	
☐ Norovirus Real Time RT-PCR Norovirus GI and GII	☐ Arbovirus Panel, MIA West Nile and SLE	☐ Hepatitis B Panel Hepatitis B Surface Antigen (HBsAg) Hepatitis B Core Total Antibody (Anti-HBc)	
☐ Influenza Real Time RT-PCR Detection and Characterization	☐ Maternal Serum Panel HCG, uE3, AFP and Inhibin A	☐ Hepatitis B Immunization (Anti-HBs)	
Epi Risk Factor _____ _____ _____ _____	☐ Herpes IgM ☐ Herpes IgG ☐ Lyme IgM ☐ Lyme IgG ☐ Lyme Total Aby	☐ Hepatitis B Core IgM Antibody (Anti-HBc IgM)	
	☐ Rubella IgG ☐ Toxo IgG ☐ CMV IgG ☐ Measles IgM ☐ Measles IgG	☐ Hepatitis C Total Antibody (Anti-HCV)	
	☐ Mumps IgG ☐ Vaccinia ☐ Varicella ☐ Other _____		
To Be Forwarded to CDC: ☐ Yes Diagnosis Suspected: _____ Contact 504-219-4646 for prior approval. Please include One CDC History form per specimen.			

TO BE COMPLETED BY STATE LABORATORY

TEMPERATURE CONDITION: