

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE

OLS USE ONLY

**THREAT-PREPAREDNESS AND BIOTERRORISM CLINICAL SPECIMEN SUBMISSION FORM**

**INSTRUCTIONS:** Specimens submitted for testing **MUST** include this fully completed submission form. Use one form per source. Use this form **only** for samples submitted to the Threat-Preparedness & Bioterrorism Response Section (BT Lab) for identifying potential Bioterrorism Agents. You **MUST** receive verbal authorization from the BT Lab prior to sending any specimens. Notify your local health department and submit a written report per their instructions. **Please print or type answers.**

**PATIENT INFORMATION**

PATIENT ID (Chart #, etc.)		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH		AGE
COUNTY OF RESIDENCE		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
STREET ADDRESS		
CITY	STATE	ZIP
PARENT OR GUARDIAN NAME (if applicable)		

**SUSPECTED ORGANISM(S)**

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**SPECIMEN INFORMATION**

Origin: <input type="checkbox"/> Serum <input type="checkbox"/> Skin <input type="checkbox"/> Blood <input type="checkbox"/> Hair <input type="checkbox"/> Gastric <input type="checkbox"/> Stool <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Wound _____ <input type="checkbox"/> Tissue _____ <input type="checkbox"/> Exudate _____ <input type="checkbox"/> Other _____	Isolation Attempted? <input type="checkbox"/> Yes # times _____ <input type="checkbox"/> No # passes _____ <input type="checkbox"/> No	Specimen Submitted as: <input type="checkbox"/> Original Material <input type="checkbox"/> Pure Isolate <input type="checkbox"/> Mixed Isolate  Submitted on: <input type="checkbox"/> Medium (specify) _____ <input type="checkbox"/> Other (specify) _____
DATE and TIME OF COLLECTION: (dd/mm/yyyy) <input type="checkbox"/> AM <input type="checkbox"/> PM		

**SUBMITTING PROVIDER INFORMATION**

SUBMITTER AGENCY		
SUBMITTER NAME and RANK		EMPLOYMENT ID (Badge #, etc.)
STREET ADDRESS		
CITY	STATE	ZIP
COUNTY	EMAIL	
PHONE NO.	FAX NO.	
NAME OF PERSON WHO SHOULD RECEIVE REPORT AT FACILITY		

**SENTINEL LEVEL TESTS PERFORMED AND RESULTS**

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**EPIDEMIOLOGIC INFORMATION**

<input type="checkbox"/> Single Case <input type="checkbox"/> Sporadic <input type="checkbox"/> Epidemic <input type="checkbox"/> Other _____	
Date of Symptom Onset: (dd/mm/yyyy)	
Description of Clinical Symptoms	
Is patient using antibiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Antibiotic(s):	
Start Date and Duration:	
Patient Employment/Trade	
Recent Travel History	Location: _____ Date: _____
Any contact with ill animal or arthropod?	<input type="checkbox"/> Pigs <input type="checkbox"/> Cattle <input type="checkbox"/> Rabbits <input type="checkbox"/> Poultry <input type="checkbox"/> Tick <input type="checkbox"/> Mosquito <input type="checkbox"/> Other _____ <input type="checkbox"/> Exposure only <input type="checkbox"/> Other _____ <input type="checkbox"/> Bite _____
Date:	Describe Animal's Illness:
Any contact with other humans with similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Contact's Illness:
Date:	
Other Notes	

**MANDATORY PRIOR NOTIFICATION INFORMATION**

LOCAL HEALTH DEPT.	CONTACT NAME	DATE	<input type="checkbox"/> AM
	COUNTY	TIME	<input type="checkbox"/> PM
INFECTIOUS DISEASE EPIDEMIOLOGY (IDEP)	CONTACT NAME	DATE	<input type="checkbox"/> AM
		TIME	<input type="checkbox"/> PM
OFFICE OF LAB SERVICES (OLS) BT LAB	CONTACT NAME	DATE	<input type="checkbox"/> AM
		TIME	<input type="checkbox"/> PM
OTHER AGENCIES CONTACTED	CONTACT NAME	DATE	<input type="checkbox"/> AM
		TIME	<input type="checkbox"/> PM

**ADDITIONAL COMMENTS OR CONCERNS**

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RESULTS REPORTED TO	DATE REPORTED	TECH INITIALS
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Signature of Submitter	Date
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FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS