

LABORATORY EXAMINATION(S) REQUESTED: <input type="checkbox"/> ANtimicrobial Susceptibility <input type="checkbox"/> HIstology <input type="checkbox"/> IDentification <input type="checkbox"/> ISolation <input type="checkbox"/> SErology (Specific Test) _____ <input type="checkbox"/> OTHer (Specify) _____					CATEGORY OF AGENT SUSPECTED: <input type="checkbox"/> BActerial <input type="checkbox"/> VIral <input type="checkbox"/> FUngal <input type="checkbox"/> RIckettsial <input type="checkbox"/> PArasitic <input type="checkbox"/> OTHer (Specify) _____				
SPECIFIC AGENT SUSPECTED: _____	OTHER ORGANISM(S) FOUND: _____	ISOLATION ATTEMPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF TIMES ISOLATED: _____	NO. OF TIMES PASSED: _____	SPECIMEN SUBMITTED IS: <input type="checkbox"/> Original Material <input type="checkbox"/> Mixed Isolate <input type="checkbox"/> Pure Isolate				
DATE SPECIMEN TAKEN: MO / DA / YR _____		ORIGIN: <input type="checkbox"/> FOod <input type="checkbox"/> ANimal <input type="checkbox"/> HUman <input type="checkbox"/> SOil (Specify) _____ <input type="checkbox"/> OTHer (Specify) _____							
SOURCE OF SPECIMEN: <input type="checkbox"/> BLood <input type="checkbox"/> CSF <input type="checkbox"/> WOund (Site) _____ <input type="checkbox"/> GAstic <input type="checkbox"/> HAir <input type="checkbox"/> EXudate (Site) _____ <input type="checkbox"/> SErum <input type="checkbox"/> SKin <input type="checkbox"/> TIssue (Specify) _____ <input type="checkbox"/> SPutum <input type="checkbox"/> STool <input type="checkbox"/> OTHer (Specify) _____ <input type="checkbox"/> URine <input type="checkbox"/> THroat <input type="checkbox"/> OTHer (Specify) _____			SUBMITTED ON: <input type="checkbox"/> MEdium _____ <input type="checkbox"/> ANimal _____ <input type="checkbox"/> TIssue Culture (Type) _____ <input type="checkbox"/> EGg <input type="checkbox"/> OTHer (Specify) _____						
SERUM INFORMATION: MO DA YR _____ <input type="checkbox"/> ACute _____ <input type="checkbox"/> COnvalescent _____ MO DA YR _____ <input type="checkbox"/> S3 _____ <input type="checkbox"/> S4 _____ <input type="checkbox"/> S5 _____			SIGNS AND SYMPTOMS: <input type="checkbox"/> FEVer Maximum Temperature: _____ Duration: _____ Days <input type="checkbox"/> CHills		CENTRAL NERVOUS SYSTEM: <input type="checkbox"/> HEadache <input type="checkbox"/> MEningismus <input type="checkbox"/> MIcrocephalus <input type="checkbox"/> HYdrocephalus <input type="checkbox"/> SEizures <input type="checkbox"/> CErebral Calcification <input type="checkbox"/> CHorea <input type="checkbox"/> PARalysis <input type="checkbox"/> OTHer _____				
IMMUNIZATIONS: (1.) _____ MO YR _____ (2.) _____ MO YR _____ (3.) _____ MO YR _____ (4.) _____ MO YR _____			SKIN: <input type="checkbox"/> MAculopapular <input type="checkbox"/> HEMorraghic <input type="checkbox"/> VEsicular <input type="checkbox"/> Erythema Nodosum <input type="checkbox"/> Erythema Marginatum <input type="checkbox"/> OTHer _____		MISCELLANEOUS: <input type="checkbox"/> JAundice <input type="checkbox"/> MYalgia <input type="checkbox"/> PLEurodynia <input type="checkbox"/> COnjunctivitis <input type="checkbox"/> CHorioretinitis <input type="checkbox"/> SPlenomegaly <input type="checkbox"/> HEpatomegaly <input type="checkbox"/> LIver Abscess/cyst <input type="checkbox"/> LYmphadenopathy <input type="checkbox"/> MUcous Membrane Lesions <input type="checkbox"/> OTHer _____				
TREATMENT: DRUGS USED <input type="checkbox"/> None (1.) _____ MO DA YR _____ MO DA YR _____ (2.) _____ MO DA YR _____ MO DA YR _____ (3.) _____ MO DA YR _____ MO DA YR _____			RESPIRATORY: <input type="checkbox"/> RHinitis <input type="checkbox"/> PUlmonary <input type="checkbox"/> PHaryngitis <input type="checkbox"/> CAlcifications <input type="checkbox"/> OTitis Media <input type="checkbox"/> PNeumonia (type) _____ <input type="checkbox"/> OTHer _____		STATE OF ILLNESS: <input type="checkbox"/> SYmptomatic <input type="checkbox"/> ASymptomatic <input type="checkbox"/> SUBacute <input type="checkbox"/> CHronic <input type="checkbox"/> DIsseminated <input type="checkbox"/> LOcalized <input type="checkbox"/> EXtraintestinal <input type="checkbox"/> OTHer _____				
EPIDEMIOLOGICAL DATA: <input type="checkbox"/> Single Case <input type="checkbox"/> SPoradic <input type="checkbox"/> COntact <input type="checkbox"/> EPidemic <input type="checkbox"/> CArrier Family Illness _____ Community Illness _____ Travel and Residence (Location) <input type="checkbox"/> Foreign _____ <input type="checkbox"/> USA _____ Animal Contacts (Species) _____ Anthropod Contacts: <input type="checkbox"/> None <input type="checkbox"/> Exposuer Only <input type="checkbox"/> Bite Type of Anthropod: _____ Suspected Source of Infection: _____									
PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION: (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.) 									

CDC 50.34 Rev. 09/2002 (BACK)

– CDC SPECIMEN SUBMISSION FORM –

CDC NUMBER	UNIT	FY	NUMBER	SUF.
------------	------	----	--------	------

Justification must be completed by State health department laboratory before specimen can be accepted by CDC. Please check the first applicable statement and when appropriate complete the statement with the *.

1. Disease suspected to be of public health importance. Specimen is:
 (a) from an outbreak. (b) from uncommon or exotic disease.
 (c) an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) from a disease for which reliable diagnostic reagents or expertise are unavailable in State.
2. Ongoing collaborative CDC/State project.
3. Confirmation of results requested for quality assurance.

*Prior arrangement for testing has been made.
 Please bring to the attention of:

(Name): _____

Completed by: _____

Date: ____/____/____

Name, Address and Phone Number of Physician or Organization:

STATE HEALTH DEPARTMENT LABORATORY ADDRESS:

STATE HEALTH
 DEPT. NO.: _____

DATE SENT
 TO CDC:
 (MM/DD/YYYY) ____/____/____

PATIENT IDENTIFICATION: (Hospital No.) _____

NAME:
 (LAST, FIRST, MI) _____

BIRTHDATE:
 (MM/DD/YYYY) ____/____/____

SEX: MALE FEMALE

CLINICAL
 DIAGNOSIS: _____

ASSOCIATED
 ILLNESS: _____

DATE OF ONSET:
 (MM/DD/YYYY) ____/____/____

FATAL? YES NO

(FOR CDC USE ONLY)		CDC NUMBER		DATE RECEIVED		
UNIT	FY	NUMBER	SUF	MO	DA	YR

REVERSE SIDE OF THIS FORM MUST BE COMPLETED

THIS FORM MUST BE EITHER PRINTED OR TYPED
 PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN

D.A.S.H.

DATE REPORTED

MO DA YR

0 3

Comments:

____/____/____

D 6 5



DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Public Health Service
 Centers for Disease Control
 Center for Infectious Diseases
 Atlanta, Georgia 30333



The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.