

*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: _____

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

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

D.A.S.H.

DATE REPORTED

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Comments: _____

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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.

LABORATORY EXAMINATION(S) REQUESTED: AN timicrobial Susceptibility HI stology ID entification IS olation SE rology (Specific Test) _____ OT her (Specify) _____				CATEGORY OF AGENT SUSPECTED: BA cterial VI ral FU ngal RI ckettsial PA rasitic OT her (Specify) _____							
SPECIFIC AGENT SUSPECTED: _____		OTHER ORGANISM(S) FOUND: _____		ISOLATION ATTEMPTED? YES NO	NO. OF TIMES ISOLATED: _____	NO. OF TIMES PASSED: _____	SPECIMEN SUBMITTED IS: Original Material Mixed Isolate Pure Isolate				
DATE SPECIMEN TAKEN: ____ MO ____ DA ____ YR ____		ORIGIN: HU man FO od SO il AN imal (Specify) _____ OT her (Specify) _____									
SOURCE OF SPECIMEN: BL ood GA stic SE rum SP utum UR ine CSF HA ir SK in ST ool TH roat WO und (Site) _____ EX udate (Site) _____ TI ssue (Specify) _____ OT her (Specify) _____					SUBMITTED ON: ME dium _____ AN imal _____ TI ssue Culture (Type) _____ EG g OT her (Specify) _____						
SERUM INFORMATION: MO ____ DA ____ YR ____ AC ute CO nvalescent			S3 _____ S4 _____ S5 _____			SIGNS AND SYMPTOMS: FE ver Maximum Temperature: _____ Duration: _____ Days CH ills			CENTRAL NERVOUS SYSTEM: HE adache ME ningismus MI crocephalus HY drocephalus SE izures CE rebral Calcification CH orea PA ralysis OT her _____		
IMMUNIZATIONS: MO ____ YR ____ (1.) _____ (2.) _____ (3.) _____ (4.) _____					SKIN: MA culopapular HE morrhagic VE sicular ER ythema Nodosum ER ythema Marginatum OT her _____				MISCELLANEOUS: JA undice MY algia PL eurodynia CO njunctivitis CH orioretinitis SP lenomegaly HE patomegaly LI ver Abscess/cyst LY mphenopathy MU cous Membrane Lesions OT her _____		
TREATMENT: DRUGS USED None MO ____ DA ____ YR ____ (1.) _____ (2.) _____ (3.) _____					RESPIRATORY: RH initis PU lmonary PH aryngitis CA lcifications OT itis Media PN eumonia (type) OT her _____			STATE OF ILLNESS: SY mmptomatic AS ymptomatic SU bacute CH ronic DI sseminated LO calized EX traintestinal OT her _____			
EPIDEMIOLOGICAL DATA: SI ngle Case SP oradic CO ntact EP idemic CA rrier Family Illness _____ Community Illness _____ Travel and Residence (Location) FO reign _____ US A _____ Animal Contacts (Species) _____ Anthropod Contacts: None Exposer Only Bite Type of Anthropod: _____ Suspected Source of Infection: _____					CARDIOVASCULAR: MY ocarditis PE ricarditis EN docarditis OT her _____				GASTROINTESTINAL: DI arrhea BL ood MU cous CO nstipation AB normal Pain VO miting OT her _____		
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.											