
Zika Update: Feb. 19, 2016

Managing Test Requests and Streamlining Documentation

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Public Health Division

Oregon
Health
Authority

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Agenda

- Zika Virus
- Criteria for Testing
- The Process
 - Orpheus
 - Specimen & Paperwork
- Public Communications
- Questions? Suggestions?



<http://www.cdc.gov/zika/geo/active-countries.html>

Zika Virus



- Flavivirus, related to West Nile and Dengue
- Transmitted primarily by mosquitoes *not* found in Oregon: *Aedes aegypti* and *Ae. albopictus*
- Infection typically causes *mild* illness, when it causes illness at all; 80% of people infected with Zika virus are asymptomatic.
- Symptoms include:
 - Fever
 - Maculopapular rash
 - Joint pains
 - Conjunctivitis (red, irritated eyes)

Zika Virus



- The chief concerns are that Zika infection during pregnancy *might* lead to microcephaly or fetal death, and might increase the risk of Guillain Barré syndrome

The Process: Overview

- Providers identify patients to test & Notify local health department (LHD)
- LHD determines if it meets criteria
 - If no, discuss/explain why
 - If yes,
 - Make sure they know which specimen to submit and how
 - Make sure they have the appropriate paperwork to fill out & answer questions
 - Enter minimum information required* into Orpheus
 - If confirmed or presumptive, complete case investigation

Criteria for Testing

- Any person (male or female) who has traveled to an affected area and within 2 weeks of travel develops **at least 2** Zika-compatible symptoms (fever, maculopapular rash, arthralgias and non-purulent conjunctivitis).

OR

- Any fetus or newborn whose mother traveled to an affected area during pregnancy and who has:
 - Microcephaly or disproportionately small as compared to infant's length, OR
 - Evidence of brain calcifications on ultrasound, OR
 - Central nervous system deficits not otherwise explained by other etiologies.

OR

- Any newborn with normal physical findings whose mother had confirmed or presumed infection with Zika virus during pregnancy.

Recommended Criteria for Testing: All Suspect Cases

- Any person (male or female) who has traveled to an affected area and within 2 weeks of travel develops **at least** 2 Zika-compatible symptoms (fever, maculopapular rash, arthralgias and non-purulent conjunctivitis).
- OR**
- Any fetus or newborn whose mother traveled to an affected area during pregnancy and who has:
 - Microcephaly or disproportionately small as compared to infant's length, OR
 - Evidence of brain calcifications on ultrasound, OR
 - Central nervous system deficits not otherwise explained by other etiologies.
- OR**
- Any newborn with normal physical findings whose mother had confirmed or presumed infection with Zika virus during pregnancy.

Expanded (Optional) Criteria for Testing: Asymptomatic Pregnant Women

- **NOTE:** CDC will test asymptomatic pregnant women with a history of travel to a region with active Zika virus transmission (not recommended, just an option)
 - **MUST** be tested between 2 – 12 weeks after returning from travel due to limitations of assay used

Criteria for Testing

- Any person (male or female) who has traveled to an affected area and within 2 weeks of travel develops **at least** 2 Zika-compatible symptoms (fever, maculopapular rash, arthralgias and non-purulent conjunctivitis).
- OR
- Any fetus or newborn whose mother traveled to an affected area during pregnancy and who has:
 - Microcephaly or disproportionately small as compared to infant's length, OR
 - Evidence of brain calcifications on ultrasound, OR
 - Central nervous system deficits not otherwise explained by other etiologies.
- OR
- Any newborn with normal physical findings whose mother had confirmed or presumed infection with Zika virus during pregnancy.

- **NOTE:** CDC will test asymptomatic pregnant women with a history of travel to a region with active Zika virus transmission → **MUST** be tested between 2 – 12 weeks after returning from travel

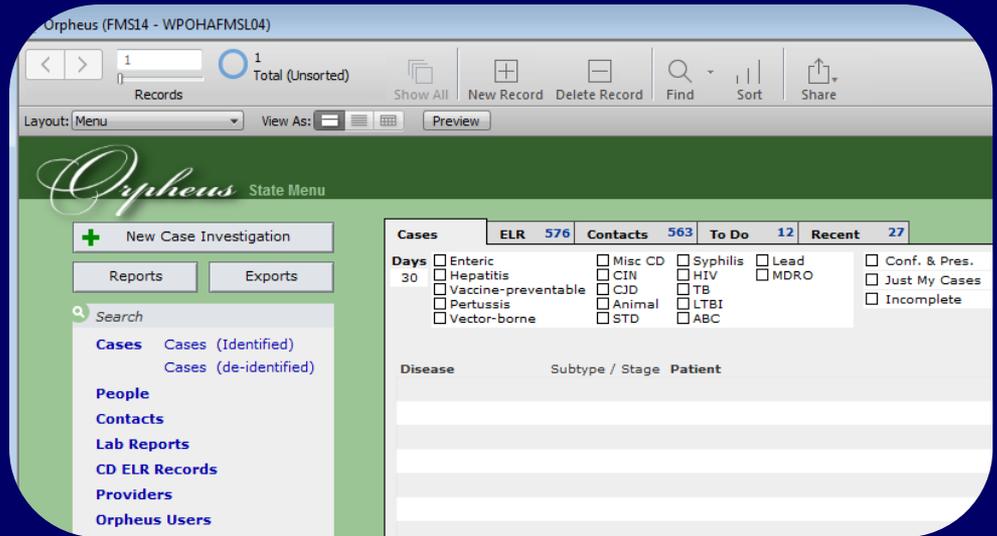
SUSPECT

UNDER INVESTIGATION

Each Patient Who Meets Criteria, We ask that Local Health Departments:

- 1) Enter person in Orpheus
- 2) Assist/make sure appropriate submission of:
 - Specimen(s)
 - Paperwork

ORPHEUS



Overview: Zika & Orpheus

- Role of Orpheus for Zika... a bit different
 - Used for case investigation and managing test requests
 - Orpheus entry by LHD necessary for testing approval by the state
- Approval Process
 - County no longer needs to call ACDP (state) for approval
 - State epis will review Orpheus regularly and coordinate with OSPHL
 - Only persons with entries into Orpheus will be tested for Zika
 - Information in Orpheus must show that CDC testing criteria met
- New button in Orpheus will allow entry of preliminary testing information (not full case investigation)
- Full case investigation needed if, and only if, case is confirmed or presumptive for Zika

The Process.... Ideally

- Provider sees patient and discusses Zika testing
- If patient-provider decide on testing, provider collects basic information described on bitly.com/zikaoregon
- Provider notifies LHD for the county in which the patient resides
- Provider communicates travel and clinical information to CD staff
 - Dates/locations of travel, pregnancy information, symptoms
 - Ensure travel to affected region: <http://www.cdc.gov/zika/geo/active-countries.html> and timing of symptoms, when relevant
- CD staff member enters basic information into Orpheus
- CD staff member ensures that specimen is sent with correct forms
 - Provider/lab can send directly to OSHPL (preferred, most efficient)
 - LHD can send to OSPHL via courier (alternate option)

Asymptomatic Pregnant Women

Orpheus Dev (FMS14 - WTOHAFMSL01)

Records: 1 Total (Unsorted)

Layout: gNewCase View As: [Icons] Preview

New Case Investigation

HOME

Create a New Case Investigation

includes a check for duplicates

Disease: Zika Bug: Zika virus

Case Status: Confirmed, Presumptive, Suspect, No Case, Syphilis Reactor, **Under Investigation**

Last Name: [Field] First Name: [Field] Middle: [Field]

DOB: [Field] or age: [Field]

Sex: F M

Institution of residence: [Field] Set

Patient's Address: [Field]

Zip Code: [Field]

City, State: [Field] OR

County: [Field]

Clear Form Cancel Create Case

Enter Case Status as
“Under Investigation”

Complete basic
demographics
and select
“Create Case”

Asymptomatic Pregnant Women

Status = "U" for Under Monitoring

Complete Pregnancy Status Here

Janis Doe DOB:01/01/80 36F Multnomah **U** Zika virus disease Onset ~ 2/12/16 SP ID 514718

Basics Labs Clinical Risks Followup Epilinks Contacts Notes Vaccine More

Identifiers (first, middle, last) Person

Janis MI Doe
800 NE Oregon St
Portland OR 97232
MULTNOMAH Special Housing
Type Phone Number 2/19/16
Type Phone Number
Email or alternate contact info

Demographics

DOB 1/1/1980
Age 36 Years
Sex F M
Preg Yes No U
Lang Language
Born Country of Birth
 Refugee
Work Worksite / School
Occ. Occupation / Grade

Race

White
 Black
 Asian
 Pacific Is.
 AI/AN
 Unknown
 Refused
 Other

Hispanic

Yes
 No
 Unknown
 Declined

Subrace

VB Disease ? Status ?

Zika virus disease Under
Subtype Sub-Subtype
Onset Date Date
Syndrome

Required questions for Zika testing approval:

Zika Testing Questions
Data Entry Instructions

Post-exposure prophylaxis

Date Drug

Print Redacted

Reporter Providers, Facilities & Labs + Provider
OK to contact Patient
Local Epi Katherine Ellingson Keep Active
Date Report Received by LHD 2/19/2016
LHD Completion Date
State Completion Date

Note History Orpheus Users View All Notes

Record 1 of 1 (134,675 total)

Asymptomatic Pregnant Women

Development Version
All-view enabled

HOME Record Entry LIST PRINT

Janis Doe DOB:01/01/80 36F Multnomah U Zika virus disease Onset ~ 2/12/16 SP ID 514718

Basics Labs Clinical Risks Followup Epilinks Contacts Notes Vaccine More

Identifiers (first, middle, last) Person
Janis MI Doe
800 NE Oregon St
Portland OR 97232
MULTNOMAH Special Housing
Type Phone Number 2/19/16
Type Phone Number
Email or alternate contact info

Demographics
DOB 1/1/1980
Age 36 Years
Sex F M
Preg Yes No U
Lang Language
Born Country of Birth
 Refugee
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Subrace

VB Disease ? Status
Zika virus disease Under
Subtype Sub-Subtype
Onset Date Date
Syndrome

Required questions for Zika testing approval:
Zika Testing Questions
Data Entry Instructions

Reporter Providers, Facilities & Labs
+ Provider

Post-exposure prophylaxis
Date Drug

Print Redacted

Record 1 of 1 (134,675 total)

For asymptomatic pregnant women:
1) Select "Under Investigation" for case status
2) Complete the Zika Testing Questions (red button)

For individuals meeting "Suspect" case definition:
1) Select "Suspect" for case status
2) Complete Zika Testing Questions (red button)

For Zika testing to be approved, all individuals must be entered into Orpheus as either "Suspect" or "Under Investigation," and the basic test questions answered. Once laboratory results are available, please update Orpheus:

*For negative test results, change case status to "No Case"

*For positive results, change case status to "Confirmed" or "Presumptive" per case definitions, and complete Risk, Clinical, and Labs tabs as you would for any other case investigation.

Click blue button for guidance on entering and following up Orpheus entries

Asymptomatic Pregnant Women

Orpheus Dev (FMS14 - WTOHAFMSL01)

1 / 134675 Found (Unsorted)

Records Show All New Record Delete Record Find Sort Share

Layout: CaseEntry View As: Preview

Record Entry Development Version All-view enabled LIST PRINT

Janis Doe DOB: 01/01/80 36F Multnomah U Zika virus disease Onset ~ 2/12/16 SP ID 514718

Basics Labs Clinical Risks Followup Epilinks Contacts Notes Vaccine More

Identifiers (first, middle, last) Person
Janis MI Doe
800 NE Oregon St
Portland OR 97232
MULTNOMAH Special Housing
Type Phone Number 2/19/16
Email or alternate contact info

Demographics
DOB 1/1/1980
Age 36 Years
Sex F M
Preg Yes No U
Lang Language
Born Country of Birth
Refugee
Work Worksite / School
Occ. Occupation / Grade
Race
 White
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Hispanic
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 Unknown
 Declined
Subrace

VB Disease Status Under
Zika virus disease
Subtype Sub-Subtype
Onset Date Date
Syndrome

Required questions for Zika testing approval:
Zika Testing Questions
Data Entry Instructions

Reporters, Facilities & Labs Provider
OK to contact Patient
Local Epi Katherine Ellingson Keep Active
Date Report Received by LHD 2/19/2016
LHD Completion Date
State Completion Date

Note History Orpheus Users View All Notes
NOTES
Click the icon to add a note.

Record 1 of 1 (134,675 total)

Complete
Zika
Testing
Questions

Asymptomatic Pregnant Women

Orpheus Dev - 2 (FMS14 - WTOHAFMSL01)

1 / 134675 Found (Unsorted)

Records Show All New Record Delete Record Find Sort Share

Layout: Answer_Zika View As: Preview Edit Layout

Questions Required for Zika Testing

Date LHD Notified

Janis Doe 36 F Multnomah Under **2/19/16** ID 514718

Click button to complete travel questions:  **Select button to enter Travel**

Symptoms Onset Date

Fever >37.8 C (100 F)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Did you have a rash?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
New or increased joint pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Irritated, red eyes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown

Pregnant? Yes No U

If yes, please answer the questions below:

First date of last menstrual cycle	<input type="text"/>
When is baby due	<input type="text"/>

If more than 12 weeks since travel return from Zika-affected region, please answer the questions below:

Date of most recent ultrasound	<input type="text"/>
Evidence of microcephaly on ultrasound	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Unknown
Evidence of brain calcifications on ultrasound?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Unknown

Asymptomatic Pregnant Women

Travel Janis Doe 36 Multnomah 02/12/16 Zika virus disease U OK

The onset date is only estimated. Ask about exposures from Saturday, 4/18/2015 through Friday, 2/12/2016

Regions Visited

- Oregon
- USA
- Canada
- Mexico
- Latin America
- Caribbean
- Europe
- Asia
- Middle East
- Africa
- Oceania
- unspecified foreign

Foreign Travel Dates

Left USA on... 11/16/2015 Never left; they just arrived

Returned/arrived USA on... 12/16/2015

Travel history here

Summary Oregon USA Canada **Mexico** Latin America Caribbean Europe Africa Middle East Asia Oceania

States

- Mexico City (DF)
- Aguascalientes
- Baja California
- Baja California Sur
- Campeche
- Chiapas
- Chihuahua
- Coahuila
- Colima
- Durango
- Guanajuato
- Guerrero
- Hidalgo
- Jalisco
- Mexico
- Michoacan
- Morelos
- Nayarit
- Nuevo Leon
- Oaxaca
- Puebla
- Queretaro
- Quintana Roo
- San Luis Potosi
- Sinaloa
- Sonora
- Tabasco
- Tamaulipas
- Tlaxcala
- Veracruz
- Yucatan
- Zacatecas

Resorts/Hot Spots

- Cabo San Lucas
- San Jose del Cabo
- Playa del Carmen
- Isla Mujeres
- Puerto Vallarta
- LaPaz
- Loreto
- Acapulco
- Huatulco
- Zihuatanejo
- Ixtapa
- Mazatlan
- San Blas
- Cancun
- Cozumel

Travel Notes

Note: exposure period intentionally long to capture any travel during pregnancy. No travel should be entered prior to pregnancy.

Travel Summary

*****FOREIGN TRAVEL*****

Foreign travel from 11/16/2015 through 12/16/2015

Mexico: Chihuahua

TRAVEL SUMMARY

This is automatically generated from the various travel layout checkboxes. It cannot be edited directly.



Asymptomatic Pregnant Women

Records 5 7 / 134677 Found (Sorted) Show All New Record Delete Record Find Sort Share

Layout: Answer_Zika View As: Preview Aa Edit Layout

Questions Required for Zika Testing

Date LHD Notified

Janis Doe 36 F Multnomah Under **2/19/16** ID 514718

Click button to complete travel questions:  *******FOREIGN TRAVEL*******
Foreign travel from 11/16/2015 through 12/16/2015
Mexico: Chihuahua

Symptoms Onset Date

Fever >37.8 C (100 F)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Did you have a rash?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
New or increased joint pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Irritated, red eyes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown

Pregnant? Yes No U

If yes, please answer the questions below:

First date of last menstrual cycle	<input type="text" value="8/10/2015"/>
When is baby due	<input type="text" value="5/16/2016"/>

If more than 12 weeks since travel return from Zika-affected region, please answer the questions below:

Date of most recent ultrasound	<input type="text"/>
Evidence of microcephaly on ultrasound	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Unknown
Evidence of brain calcifications on ultrasound?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Unknown

Travel history auto-populates here

Complete basic pregnancy info

Suspect Case Example 1: returning traveler with symptom onset w/in 2wks of return

Orpheus Dev (FMS14 - WTOHAFMSL01)

Records: 1 Total (Unsorted)

Layout: gNewCase View As: Preview

New Case Investigation

HOME

Create a New Case Investigation

includes a check for duplicates

Disease zika Bug: Zika virus

Case Status

Last Name

First Name

Middle

DOB

or age

Sex F M

Institution of residence

Patient's Address 800 NE Oregon St

Zip Code 97232

City, State Portland OR

County Multnomah

Enter Case Status as
"Suspect"

Suspect Case Example 1: returning traveler with symptom onset w/in 2wks of return

Status = "S" for Suspect

The screenshot displays the 'Case Entry' interface for a patient named James Doe. The patient's status is 'Suspect' (S) for Zika virus disease, with an onset date of 2/12/16. The interface includes tabs for Basics, Labs, Clinical, Risks, Followup, Eplinks, Contacts, Notes, Vaccine, and More. The 'Basics' tab is active, showing patient identifiers (James Doe, 800 NE Oregon St, Portland, OR 97232), demographics (DOB 1/1/1980, Age 36, Sex M), and clinical information (Zika virus disease, Status Suspect). A red box highlights the 'Zika Testing Questions' button, which is part of the 'Required questions for Zika testing approval' section. Other buttons include 'Data Entry Instructions' and 'Print Redacted'. The interface also shows a 'Providers, Facilities & Labs' section with a reporter (Katherine Ellingson) and a 'Note History' section. The bottom right corner indicates 'Record 1 of 1 (134,676 total)'.

Go straight to Zika Testing Questions

Suspect Case Example 1: returning traveler with symptom onset w/in 2wks of return

Travel James Doe 36 Multnomah 02/15/16 Zika virus disease S OK

Ask about exposures from Tuesday, 4/21/2015 through Monday, 2/15/2016

Regions Visited

- Oregon
- USA
- Canada
- Mexico
- Latin America
- Caribbean
- Europe
- Asia
- Middle East
- Africa
- Oceania
- unspecified foreign

Foreign Travel Dates

Left USA on... 12/23/2015

Never left; they just arrived

Returned/arrived USA on... 2/11/2016

Summary Oregon USA Canada **Mexico** Latin America Caribbean Europe Africa Middle East Asia Oceania

States

- Mexico City (DF)
- Aguascalientes
- Baja California
- Baja California Sur
- Campeche
- Chiapas
- Chihuahua
- Coahuila
- Colima
- Durango
- Guanajuato
- Guerrero
- Hidalgo
- Jalisco
- Mexico
- Michoacan
- Morelos
- Nayarit
- Nuevo Leon
- Oaxaca
- Puebla
- Queretaro
- Quintana Roo
- San Luis Potosi
- Sinaloa
- Sonora
- Tabasco
- Tamaulipas
- Tlaxcala
- Veracruz
- Yucatan
- Zacatecas

Resorts/Hot Spots

- Cabo San Lucas
- San Jose del Cabo
- Playa del Carmen
- Isla Mujeres
- Puerto Vallarta
- LaPaz
- Loreto
- Acapulco
- Huatulco
- Zihuatanejo
- Ixtapa
- Mazatlan
- San Blas
- Cancun
- Cozumel

Travel Notes

Note: exposure period intentionally long to capture any travel during pregnancy. Travel for non-pregnant people should only be entered if within 2 weeks of symptom onset

Cities

- Mexico City
- Guadalajara
- Juarez
- Tijuana
- Leon
- Monterrey

Travel Summary

*****FOREIGN TRAVEL*****

Foreign travel from 12/23/2015 through 2/11/2016

Mexico: Chihuahua

Suspect Case Example 1: returning traveler with symptom onset w/in 2wks of return

Questions Required for Zika Testing

Date LHD Notified

James Doe 36 M Multnomah Suspect 2/19/16 ID 514719

Click button to complete travel questions: 

*****FOREIGN TRAVEL*****
Foreign travel from 12/23/2015 through 2/11/2016
Mexico: Chihuahua

← Travel history auto-populates here

Symptoms Onset Date

Fever >37.8 C (100 F)	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Did you have a rash?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
New or increased joint pain	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Irritated, red eyes	<input type="radio"/> Yes	<input checked="" type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown

↖ No pregnancy questions

Note: at least 2 symptoms must be checked

Suspect Case Example 2: pregnant woman with ultrasound Findings

Development Version All-view enabled LIST PRINT

Case Entry

HOME

Jennifer Doe DOB: 01/01/80 36 F Multnomah **S** Zika virus disease Onset ~ 2/12/16 SP ID 514720

Basics Labs Clinical Risks Followup Epilinks Contacts Notes Vaccine More

Identifiers (first, middle, last) Person

Jennifer MI Doe
800 NE Oregon St
Portland OR 97232
MULTNOMAH Special Housing
Type Phone Number 2/19/16
Type Phone Number
Email or alternate contact info

Demographics

DOB 1/1/1980
Age 36 Years
Sex F M
Preg Yes No U
Lang Language
Born Country of Birth
 Refugee
Work Worksite / Street
Occ. Occupation / Grade

Race
 White
 Black
 Asian
 Pacific Is.
 AI/AN
 Unknown
 Refused
 Other

Hispanic
 Yes
 No
 Unknown
 Declined

Subrace

VB Disease ? Status

Zika virus disease Suspect
Subtype Sub-Subtype
Onset Date Date
Syndrome

Providers, Facilities & Labs + Provider

Reporter
OK to contact Patient
Local Epi Katherine Ellingson Keep Active
Date Report Received by LHD 2/19/2016
LHD Completion Date
State Completion Date

Note History Orpheus Users View All Notes

Record 1 of 1 (134,677 total)

100 Browse

Status = "S" for Suspect

Go to Zika Testing Questions

Enter Pregnancy Status

Zika Testing Questions

Data Entry Instructions

Suspect Case Example 2: Pregnant Woman with Ultrasound Findings

Orpheus Dev - 2 (FMS14 - WTOHAFMSL01)

1 / 134677 Found (Unsorted)

Records Show All New Record Delete Record Find Sort Share

Layout: Answer_Zika View As: Preview

Questions Required for Zika Testing

Date LHD Notified

Jennifer Doe 36 F Multnomah Suspect 2/19/16 ID 514720

Click button to complete travel questions: [Travel](#) *****FOREIGN TRAVEL*****

Foreign travel from 8/12/2015 through 11/17/2015
Caribbean: Haiti

Symptoms Onset Date

Fever >37.8 C (100 F)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Did you have a rash?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
New or increased joint pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Irritated, red eyes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown

Pregnant? Yes No U

If yes, please answer the questions below:

First date of last menstrual cycle: 6/15/2015

When is baby due: 3/21/2016

If more than 12 weeks since travel return from Zika-affected region, please answer the questions below:

Date of most recent ultrasound: 1/22/2016

Evidence of microcephaly on ultrasound	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown
Evidence of brain calcifications on ultrasound?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused	<input type="radio"/> Unknown

Enter travel history

Complete all pregnancy related questions

VIROLOGY/IMMUNOLOGY REQUEST
 Oregon State Public Health Laboratory
 P.O. Box 275, Portland, OR 97207-0275
 Information: 503-693-4100

Submitting facility: _____

PATIENT INFORMATION

Patient last name, first, middle initial: _____

Date of birth (mm/dd/yyyy): _____ Female Male Patient ID/Chart number: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander Multi-race Other Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Patient street address: _____

City: _____ State: _____ ZIP: _____

County of residence: _____

Date of collection: _____ Outbreak number: _____ Study: _____

PATIENT INSURANCE INFORMATION

Insurance/Health plan name: None Confidential

Policy no./Member ID: _____ Group ID: _____

Diagnosis/CD-10 code for test: _____

Public Health Program eligible patient:
 (for participating locations only)
 STD Program CCare Other: _____

SPECIMEN INFORMATION

Specimen source: _____ Illness onset (mm/dd/yyyy): _____

Blood Oral Fluid NP Swab Stool Serum Other: _____

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBsAg: HEPATITIS B SURFACE ANTIGEN
 HBcAb: HEPATITIS B CORE ANTIBODY
 HBcM: HEPATITIS B CORE IGM ANTIBODY

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

CDC Specimen Submission Information

Specimen Origin: _____

Test order name: _____

Suspected Agent: _____

Patient Name: _____ Study #: _____

Birthdate: _____ Age: _____ Age Units: _____ Sex: _____
DDMM/YYYY Days Months Years

Patient ID: _____

Clinical Diagnosis: _____

Date of onset: _____ Fatal: Yes No Date of Death: _____
DDMM/YYYY DDMMYYYY

Specimen Collection Date: _____ Time: _____
DDMMYYYY Hour Minute

Material Submitted: _____ Specimen Source (type): _____

Specimen Source Modifier: _____ Specimen Source site: _____

Specimen source site modifier: _____ Collection Method: _____

Treatment of specimen: _____ Transport medium/ Specimen preservative: _____

Specimen Handling: _____

Ordering Clinician: _____ Institution Name: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____ Fax: _____

Point of contact: _____ Phone: _____
(Person to be contacted if there is a question regarding this order)

SPECIMEN SUBMISSION PAPERWORK

2) Assist/Make sure appropriate submission of:

- Specimen(s)
 - Serum must be collected. Other specimen sources may be requested based on patient case history. Specimens are to be refrigerated pending and during transport to the OSPHL, with the *exception* of tissue specimens which should be frozen.
 - Any way to get specimen to OSPHL - courier preferred
 - We are always available to help with questions if needed 971-673-1111

2) Assist/Make sure appropriate submission of:

- Specimen(s)
 - Serum must be collected. Other specimen sources may be requested based on patient case history. Specimens are to be refrigerated pending and during transport to the OSPHL, with the *exception* of tissue specimens which should be frozen.
 - Any way to get specimen to OSPHL - courier preferred
- Paperwork
 - OSPHL CDC Submission form
 - OSPHL Virology/Immunology form

Available at bitly.com/OR-CDC-Testing

cdc-form (8).docx [Compatibility Mode] - Word

FILE HOME INSERT DESIGN PAGE LAYOUT REFERENCES MAILINGS REVIEW VIEW EndNote X6

Arial 16 A⁺ A⁻ Aa Font Paragraph Styles

Fisher Emily A

Find Replace Select Editing

CDC Specimen Submission Information

Specimen Origin:

Test order name:

Suspected Agent:

Patient Name: Study #:

Birthdate: Age: Age Units: Sex:

DDMM/YYYY Days / Months / Years

Patient ID:

Clinical Diagnosis:

Date of onset: Fatal: Yes No Date of Death:

DDMM/YYYY DDMM/YYYY

Specimen Collection Date: Time:

DDMM/YYYY Hour: Minute

Material Submitted: Specimen Source (type):

Specimen Source Modifier: Specimen Source site:

Specimen source site modifier: Collection Method:

Treatment of specimen: Transport medium/ Specimen preservative:

Specimen Handling:

Ordering Clinician: Institution Name:

Street Address: City:

State: Zip Code: Phone: Fax:

Point of contact: Phone:

(Person to be contacted if there is a question regarding this order)

Patient History

Patient Name: And/Ot Patient ID:

Last Name First Name

Brief Clinical Summary (include signs, symptoms, and underlying illnesses if known):

State of Illness:

Symptomatic
 Asymptomatic
 Acute
 Chronic
 Convalescent
 Recovered

Type of Infection:

Upper Respiratory
 Lower Respiratory
 Cardiovascular
 Gastrointestinal
 Skin/soft tissue
 Urinary tract
 Disseminated
 Other

Sepsis
 Ocular
 Joint/bone
 Genital
 Central Nervous System

Therapeutic Agent(s) During Illness:

Agent	Start Date	End Date
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>

MM/DD/YYYY

Epidemiological Data

Extent

Isolated Cases
 Carrier
 Contact
 Outbreak:
 Family #
 Community
 Healthcare-associated
 Epidemic

Travel History

Travel: Dates of travel: to

MM/DD/YYYY

Travel: Foreign (Countries): Travel: United States (States):

Foreign Residence (country): United State Residence (state):

Note: Additional states or countries or travel should be entered in the Brief Summary Field.

Exposure History

Exposure:

Type of Exposure:

Animal Arthropod

Common Name:

Scientific Name:

Previous Laboratory Results: (Or attach copy of test results)

Relevant Immunization History

Immunizations: Date Received:

1. <input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>

MM/DD/YYYY

PAGE 1 OF 2 135 WORDS 79%

OSPHL Virology/Immunology form

VIROLOGY/IMMUNOLOGY REQUEST
 Oregon State Public Health Laboratory
 P.O. Box 275, Portland, OR 97207-0275
 Information: 503-693-4100

Submitting facility: _____
 Ordering clinician: _____
 Contact number: _____

PATIENT INFORMATION

Patient last name, first, middle initial: _____
 Date of birth (mm/dd/yyyy): Female Male Patient ID/Chart number: _____
 Race: American Indian or Alaska Native Asian Hispanic or Latino
 Black or African American Not Hispanic or Latino
 Native Hawaiian or Other Pacific Islander White Unknown
 Multi-race Other Unknown Declined Declined
 Ethnicity: _____
 Patient street address: _____
 City: _____ State: _____ ZIP: _____
 County of residence: _____
 Date of collection: _____ Outbreak number: _____ Study: _____

PATIENT INSURANCE INFORMATION

Insurance/Health plan name: None Confidential
 Policy no./Member ID: _____ Group ID: _____
 Diagnosis/ICD-10 code for test: _____
 Public Health Program eligible patient: (for participating locations only)
 STD Program OCare Other: _____

SPECIMEN INFORMATION

Specimen source: Blood Oral Fluid NP Swab Stool Serum Other: _____ Illness onset (mm/dd/yyyy): _____

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/IGC

CT/IGC: CHLAMYDIA/GONORRHEA BY NAAT (Nucleic Acid Amplification Testing)
 VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL
 OTHER: _____
 Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

→ Required for all tests
 → Required if applicable
 → Required if OSPHL is billing insurance payer
 → Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____
 Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown
 If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown
 Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) OTHREF: Mumps IgG
 OTHREF: Rubella IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION. Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL IVDI: Viral Gastroenteritis Panel
 CDC SENDOUT FOR: _____ (REQUIRES COMPLETED CDC FORM 50-34)
 Other: _____

OHA 0042 (8/2015) 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

Available in most clinical laboratories in Oregon, or call OSPHL Client Services to obtain copies.

OSPHL Virology/Immunology form

VIROLOGY/IMMUNOLOGY REQUEST
Oregon State Public Health Laboratory
P.O. Box 275, Portland, OR 97207-0275

Submitting facility: _____

Ordering clinician: _____

Contact number: _____

PATIENT INFORMATION

Patient last name, first, middle initial: _____

Date of birth (mm/dd/yyyy): _____ Female Male Patient ID/Chart number: _____

Race: American Indian or Alaska Native Asian Hispanic or Latino
 Black or African American Not Hispanic or Latino
 Native Hawaiian or Other Pacific Islander White Unknown
 Multi-race Other Unknown Declined Declined

Ethnicity: _____

Patient street address: _____

City: _____ State: _____ ZIP: _____

County of residence: _____

Date of collection: _____ Outbreak number: _____ Study: _____

PATIENT INSURANCE INFORMATION

Insurance/Health plan name: None Confidential

Policy no./Member ID: _____ Group ID: _____

Diagnosis/ICD-10 code for test: _____

Public Health Program eligible patient: (for participating locations only)
 STD Program CCare Other: _____

SPECIMEN INFORMATION

Specimen source: Blood Oral Fluid NP Swab Stool Serum Other: _____ Illness onset (mm/dd/yyyy): _____

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/IGC

CT/IGC: CHLAMYDIA/GONORRHEA BY NAAT (nucleic Acid Amplification Testing)
 VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL
 OTHER: _____

Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

Required for all tests

Required if applicable

Required if OSPHL is billing insurance payer

Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) OTHREF: Mumps IgG
 OTHREF: Rubella IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION. Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL IVD: Viral Gastroenteritis Panel
 CDC SENDOUT FOR: _____ (REQUIRES COMPLETED CDC FORM 50-34)
 Other: _____

OHA 0042 (8/2015) Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL Virology/Immunology form

PATIENT INFORMATION		
Patient last name, first, middle initial:		
Date of birth (mm/dd/yyyy):	<input type="checkbox"/> Female <input type="checkbox"/> Male	Patient ID/Chart number:
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Multi-race <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined
Patient street address:		
City:	State:	ZIP:
County of residence:		
Date of collection:	Outbreak number:	Study:

OSPHL Virology/Immunology form

Submitting facility:	
Ordering clinician:	
Contact number:	
PATIENT INSURANCE INFORMATION	
Insurance/Health plan name: <input type="checkbox"/> None <input type="checkbox"/> Confidential	
Policy no./Member ID:	Group ID:
Diagnosis/ICD-10 code for test:	
Public Health Program eligible patient: (for participating locations only)	
<input type="checkbox"/> STD Program <input type="checkbox"/> CCare <input type="checkbox"/> Other: _____	

OSPHL Virology/Immunology form

Submitting facility:	
Ordering clinician:	
Contact number:	
PATIENT INSURANCE INFORMATION	
Insurance/Health plan name: <input type="checkbox"/> None <input type="checkbox"/> Confidential	
Policy no./Member ID:	Group ID:
Diagnosis/ICD-10 code for test:	
Public Health program eligible patient: (for participating locations only)	
<input type="checkbox"/> STD Program <input type="checkbox"/> CCare <input type="checkbox"/> Other: _____	

OSPHL Virology/Immunology form

SPECIMEN INFORMATION

Specimen source:

Blood Oral Fluid NP Swab Stool Serum Other: _____

Illness onset (mm/dd/yyyy):

OSPHL Virology/Immunology form

 VIROLOGY/IMMUNOLOGY REQUEST Oregon State Public Health Laboratory P.O. Box 275, Portland, OR 97207-0275 Information: 503-693-4100		Submitting facility:
PATIENT INFORMATION Patient last name, first, middle initial: _____ Date of birth (mm/dd/yyyy): _____ <input type="checkbox"/> Female <input type="checkbox"/> Male Patient ID/Chart number: _____ Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Black or African American <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Multi-race <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined <input type="checkbox"/> Declined Ethnicity: <input type="checkbox"/> Declined Patient street address: _____ City: _____ State: _____ ZIP: _____ County of residence: _____ Date of collection: _____ Outbreak number: _____ Study: _____		Ordering clinician: _____ Contact number: _____
SPECIMEN INFORMATION Specimen source: _____ Illness onset (mm/dd/yyyy): _____ <input type="checkbox"/> Blood <input type="checkbox"/> Oral Fluid <input type="checkbox"/> NP <input type="checkbox"/> Saliva <input type="checkbox"/> Stool <input type="checkbox"/> Serum <input type="checkbox"/> Other		PATIENT INSURANCE INFORMATION Insurance/Health plan name: <input type="checkbox"/> None <input type="checkbox"/> Confidential Policy no./Member ID: _____ Group ID: _____ Diagnosis/ICD-10 code for test: _____ Public Health Program eligible patient: (for participating locations only) <input type="checkbox"/> STD Program <input type="checkbox"/> CCare <input type="checkbox"/> Other: _____
TESTS REQUESTED		
HEPATITIS <input type="checkbox"/> HAVM: HEPATITIS A IGM ANTIBODY <input type="checkbox"/> HAVT: HEPATITIS A TOTAL ANTIBODY <input type="checkbox"/> HBSAG: HEPATITIS B SURFACE ANTIGEN <input type="checkbox"/> HBCT: HEPATITIS B CORE ANTIBODY <input type="checkbox"/> HBCM: HEPATITIS B CORE IGM ANTIBODY <input type="checkbox"/> HBSAB: HEPATITIS B SURFACE ANTIBODY <input type="checkbox"/> HCV: HEPATITIS C ANTIBODY <input type="checkbox"/> HEPB Carrier: HEPATITIS B CARRIER <input type="checkbox"/> HEPB Contact: HEPATITIS B CONTACT <input type="checkbox"/> HBIN: INFANT OF HBV@ MOM <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> HBCT: PRE-VACCINE SCREEN FOR HBV <input type="checkbox"/> HBSAB: POST-VACCINE SCREEN FOR HBV		HIV <input type="checkbox"/> HIV: HIV-1/HIV-2 ANTIBODY SCREEN <input type="checkbox"/> CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST <input type="checkbox"/> FOLLOW-UP OF INVALID RAPID TEST <input type="checkbox"/> OTHER: _____ Previous HIV testing (including rapid tests done today): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Unknown If YES, last test result was: <input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> Prelim Pos <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown Month of last test: _____ Year: _____
SYPHILIS <input type="checkbox"/> RPR <input type="checkbox"/> FTA-ABS (DS) <input type="checkbox"/> OTHER: _____		MISCELLANEOUS SEROLOGY <input type="checkbox"/> BRU TOT: BRUCELLA <input type="checkbox"/> RUB: RUBELLA IgG <input type="checkbox"/> HANTA: HANTAVIRUS <input type="checkbox"/> TUL: TULAREMIA <input type="checkbox"/> LEPTO: LEPTOSPIRA <input type="checkbox"/> VZV: VARICELLA IgG <input type="checkbox"/> PARVO: PARVOVIRUS <input type="checkbox"/> WNV: WEST NILE VIRUS <input type="checkbox"/> RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) <input type="checkbox"/> OTHREF: Mumps IgG <input type="checkbox"/> OTHREF: Rubella IgG
CT/IGC <input type="checkbox"/> CT/IGC: CHLAMYDIA/GONORRHEA BY NAAT (Note: Add Amplification testing) <input type="checkbox"/> VAG/Patient <input type="checkbox"/> VAG/Clinician <input type="checkbox"/> CERVICAL <input type="checkbox"/> URINE <input type="checkbox"/> URETHRAL <input type="checkbox"/> RECT/Patient <input type="checkbox"/> RECT/Clinician <input type="checkbox"/> PHARYNGEAL <input type="checkbox"/> OTHER: _____ Is the patient pregnant? (Based on patient report or medical record) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		VIRUS ISOLATION (See special handling instructions on page 2) <input type="checkbox"/> VIS: VIRUS ISOLATION- Suspected agent: _____ <input type="checkbox"/> MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE <input type="checkbox"/> OTHER: _____
COMMENTS Required for all tests _____ Required if applicable _____ Required if OSPHL is billing insurance payer _____ Requested for Public Health Program Tests (STD, etc.) _____		OTHER <input type="checkbox"/> MOL NOV: NOROVIRUS (Requires an outbreak number) <input type="checkbox"/> MOL RVP: Respiratory Virus Panel <input type="checkbox"/> MOL UVD: Viral Gastroenteritis Panel <input type="checkbox"/> CDC SENDOUT FOR: _____ (REQUIRES COMPLETED CDC FORM 50-34) <input type="checkbox"/> Other: _____
OHA 0042 (8/2015) _____ 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB		

OSPHL Virology/Immunology form

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/GC

CT/GC: CHLAMYDIA/GONORRHEA BY NAAT (Nucleic Acid Amplification Testing)
 VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL
 OTHER: _____

Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

→ Required for all tests
 → Required if applicable
 → Required if OSPHL is billing insurance payer
 → Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY OTHREF: Mumps IgG
 (RMSF, Murine typhus, Q fever) OTHREF: Rubeola IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION: Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL UVD: Viral Gastroenteritis Panel
 CDC SENDOUT FOR: _____
 (REQUIRES COMPLETED CDC FORM 50-34)
 Other: _____

OHA 0042 (8/2015) State license# 101 CLIA# 36D0050024 NI# 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL Virology/Immunology form

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/GC

CT/GC: CHLAMYDIA/GONORRHEA BY NAAT (Nucleic Acid Amplification Testing)
 VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL
 OTHER: _____

Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

→ Required for all tests
 → Required if applicable
 → Required if OSPHL is billing insurance payer
 → Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) OTHREF: Mumps IgG
 OTHREF: Rubeola IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION: Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL UVD: Viral Gastroenteritis Panel
 CDC SENDOUT FOR: _____
 (REQUIRES COMPLETED CDC FORM 50-34)
 Other: _____

OHA 0042 (8/2015) State license# 101 CLIA# 36D0050024 PI # 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL Virology/Immunology form

TESTS REQUESTED

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/GC

CT/GC: CHLAMYDIA/GONORRHEA BY NAAT (Nucleic Acid Amplification Testing)
 VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL
 OTHER: _____

Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

→ Required for all tests
 → Required if applicable
 → Required if OSPHL is billing insurance payer
 → Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) OTHREF: Mumps IgG
 OTHREF: Rubeola IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION: Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL UVD: Viral Gastroenteritis Panel
 CDC SENDOUT FOR: Zika
 (REQUIRES COMPLETED CDC FORM 50-34)
 Other: _____

OHA 0042 (8/2015) State license# 101 CLIA# 36D0050024 NI# 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL Virology/Immunology form



VIROLOGY/IMMUNOLOGY REQUEST
Oregon State Public Health Laboratory
P.O. Box 275, Portland, OR 97207-0275
Information: 503-959-4100

Submitting facility: _____

Ordering clinician: _____

Contact number: _____

PATIENT INFORMATION

Patient last name, first, middle initial: _____

Date of birth (mm/dd/yyyy): _____ Female Male Patient ID/Chart number: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Multi-race Other Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Patient street address: _____

City: _____ State: _____ ZIP: _____

County of residence: _____

Date of collection: _____ Outbreak number: _____ Study: _____

PATIENT INSURANCE INFORMATION

Insurance/Health plan name: None Confidential

Policy no./Member ID: _____ Group ID: _____

Diagnosis/ICD-10 code for test: _____

Public Health Program eligible patient: (for participating locations only)

STD Program CCare Other: _____

PECIMEN INFORMATION

Specimen source: Blood Oral Fluid NP Swab Stool Serum Other: _____

Illness onset (mm/dd/yyyy): _____

HEPATITIS

HAVM: HEPATITIS A IGM ANTIBODY
 HAVT: HEPATITIS A TOTAL ANTIBODY
 HBSAG: HEPATITIS B SURFACE ANTIGEN
 HBCT: HEPATITIS B CORE ANTIBODY
 HBCM: HEPATITIS B CORE IGM ANTIBODY
 HBSAB: HEPATITIS B SURFACE ANTIBODY
 HCV: HEPATITIS C ANTIBODY
 HEPB Carrier: HEPATITIS B CARRIER
 HEPB Contact: HEPATITIS B CONTACT
 HBIN: INFANT OF HBV@ MOM
 OTHER: _____
 HBCT: PRE-VACCINE SCREEN FOR HBV
 HBSAB: POST-VACCINE SCREEN FOR HBV

SYPHILIS

RPR FTA-ABS (DS) OTHER: _____

CT/GC

CTGC: CHLAMYDIA/GONORRHEA BY NAAT (Nucleic Acid Amplification Testing)

VAG/Patient VAG/Clinician CERVICAL URINE
 URETHRAL RECT/Patient RECT/Clinician
 PHARYNGEAL

OTHER: _____

Is the patient pregnant? (Based on patient report or medical record)
 Yes No Unknown

COMMENTS

→ Required for all tests

→ Required if applicable

→ Required if OSPHL is billing insurance payer

→ Requested for Public Health Program Tests (STD, etc.)

HIV

HIV: HIV-1/HIV-2 ANTIBODY SCREEN
 CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
 FOLLOW-UP OF INVALID RAPID TEST
 OTHER: _____

Previous HIV testing (including rapid tests done today):
 Yes No Declined Unknown

If YES, last test result was:
 NEG POS Prelim Pos Indeterminate Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

BRU TOT: BRUCELLA RUB: RUBELLA IgG
 HANTA: HANTAVIRUS TUL: TULAREMIA
 LEPTO: LEPTOSPIRA VZV: VARICELLA IgG
 PARVO: PARVOVIRUS WNV: WEST NILE VIRUS
 RICK: RICKETTSIAL BATTERY (RMSF, Murine typhus, Q fever) OTHREF: Mumps IgG
 OTHREF: Rubeola IgG
 OTHER: _____

VIRUS ISOLATION (See special handling instructions on page 2.)

VIS: VIRUS ISOLATION: Suspected agent: _____
 MOL IA/IB QUAL: INFLUENZA SPECIMEN OR ISOLATE SUBMITTED FOR CDC/WHO SURVEILLANCE
 OTHER: _____

OTHER

MOL NOV: NOROVIRUS (Requires an outbreak number)
 MOL RVP: Respiratory Virus Panel
 MOL UVD: Viral Gastroenteritis Panel
CDC SENDOUT FOR: _____
(REQUIRES COMPLETED CDC FORM 50-34)

Other: _____

Zika

Public Communications

- Oregon Health Authority is the lead on any Zika communication – If you want to discuss media, call us at 971-673-1111.
- Websites:
 - For LHDs – [Diseases A – Z page](#)
 - For Healthcare Providers – bitly.com/zikaoregon – PLEASE feel free to push out to providers!
 - For Public and Case Counts – healthoregon.org/zika
 - Lab Stuff – bitly.com/OR-CDC-Testing

Questions? Suggestions?

- Thank you!

Next Steps:

- Work on Spanish language content for OHA websites
 - Currently CDC has Spanish language content available that OHA links to
- Link OSPHL CDC Submission Form to Orpheus case
 - Will try for single case report form if possible, for now still 2 forms + Orpheus entry
- Work on and provide talking points for LHD regarding no testing for worried well in English and Spanish