
Epi and Lab Update: July 12, 2016

Instructions for entering Orpheus cases (edited, 10/10/16
version of original PowerPoint presentation)

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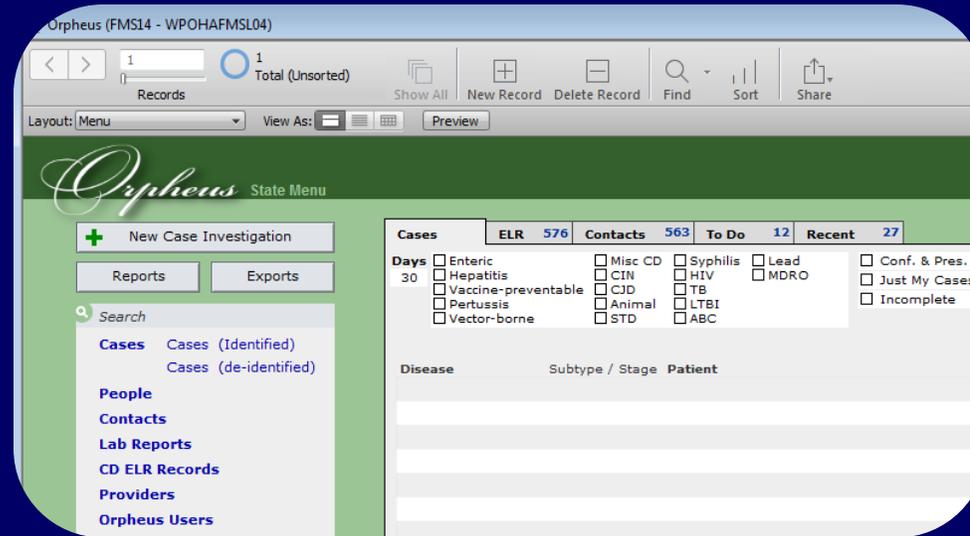
Public Health Division



(Enter) DEPARTMENT (ALL CAPS)

(Enter) Division or Office (Mixed Case)

ORPHEUS



Overview: Zika & Orpheus

- Orpheus is used for case investigation and managing testing
 - Orpheus entry by LHD necessary for testing approval by the state
- Approval Process
 - County does not need to call ACDP (state) for approval
 - State epi's review Orpheus regularly and coordinate with OSPHL
 - Only persons with entries into Orpheus will be tested for Zika at OSPHL
 - Information in Orpheus must show that CDC testing criteria met
- Button in Orpheus allows 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 patient's county of residence
- 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 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

- Enter case status as “Under Investigation” and create case
- Complete Pregnancy Status on case page
- Complete “Zika Testing” questions (red button on case page)
- Complete travel history and fill out pregnancy dates (LMM, EDD)
- **Link ELR to case and update case status**
- **If status is confirmed by test results, follow up with provider or case to ask questions on the Clinical Tab**

Asymptomatic Pregnant Women

Records 5 7 / 134677 Found (Sorted) 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:  *******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

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

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

States	Resorts/Hot Spots	Travel Notes
<input type="checkbox"/> Mexico City (DF)	<input type="checkbox"/> Cabo San Lucas	
<input type="checkbox"/> Aguascalientes	<input type="checkbox"/> San Jose del Cabo	
<input type="checkbox"/> Baja California	<input type="checkbox"/> Playa del Carmen	
<input type="checkbox"/> Baja California Sur	<input type="checkbox"/> Isla Mujeres	
<input type="checkbox"/> Campeche	<input type="checkbox"/> Puerto Vallarta	
<input type="checkbox"/> Chiapas	<input type="checkbox"/> LaPaz	
<input checked="" type="checkbox"/> Chihuahua	<input type="checkbox"/> Loreto	
<input type="checkbox"/> Coahuila	<input type="checkbox"/> Acapulco	
<input type="checkbox"/> Colima	<input type="checkbox"/> Huatulco	
<input type="checkbox"/> Durango	<input type="checkbox"/> Zihuatanejo	
<input type="checkbox"/> Guanajuato	<input type="checkbox"/> Ixtapa	
<input type="checkbox"/> Guerrero	<input type="checkbox"/> Mazatlan	
<input type="checkbox"/> Hidalgo	<input type="checkbox"/> San Blas	
<input type="checkbox"/> Jalisco	<input type="checkbox"/> Cancun	
<input type="checkbox"/> Mexico	<input type="checkbox"/> Cozumel	
<input type="checkbox"/> Michoacan		

Cities

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



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.

Note: exposure period intentionally long to capture any possible exposure during pregnancy.

Asymptomatic Pregnant Women

Basics Labs ¹ Clinical Risks Followup Epilinks Contacts ¹ Notes

Ask about exposures from Thursday, 8/6/2015 through Wednesday, 6/1/2016

Onset Indeterminate

Symptomatic? Yes No R ?

6/1/2016

Date

Diagnosis Date

GC Beta Beta

Symptom	Answer	Notes	Ask Clinical Questions
Flacid paralysis			
Fever			
Rash			
Acute arthralgias			
Non-purulent conjunctivitis			
Headache			
Myalgia			
Vomiting			
Diarrhea			
Ulcer			
edema			
hematospermia			
Pregnant			
Is case an infant?			
Other			
Vaccinated Yellow Fever?			
Vaccinated Japanese			
Vaccinated Tickborne			
History of Dengue			

If case is confirmed, complete Clinical Tab questions AND country of birth, race and ethnicity

Suspect Case Example 1: Returning Traveler with Symptom Onset w/in 2wks of Return

- Enter case status as “Suspect” and create case
- Complete Pregnancy Status on case page
- Complete “Zika Testing” questions (red button on case page)
- Complete travel history and fill out pregnancy dates (LMM, EDD) *if applicable*
- **Link ELR to case and update case status**
- **If status is confirmed by test results, follow up with provider or case to ask questions on the Clinical Tab**

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

Travel Summary

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

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

Mexico: Chihuahua

Cities

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



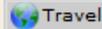
Note: exposure period intentionally long to capture any travel during pregnancy. Travel for non-pregnant people should only be entered if within 2 weeks of symptom onset

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 2/15/2016

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 1 symptom must be checked

Suspect Case Example 2: Pregnant Woman with Ultrasound Findings

- Enter case status as “Suspect” and create case for mom
- Complete Pregnancy Status on case page
- Complete “Zika Testing” questions (red button on case page)
- Complete travel history and fill out pregnancy dates (LMM, EDD)
- **Link ELR to case and update case status**
- **Follow up with provider or case to ask questions on the Clinical Tab**
- **May need to make a plan with provider for collecting specimens on neonate upon delivery (see IG)**
- **Upon birth, make new case for neonate (typically “Under Investigation” unless evidence of Zika virus infection is found) for tracking purposes**

Suspect Case Example 2: Pregnant Woman with Ultrasound Findings

Status = "S" for Suspect

Case Entry Development Version All-view enabled LIST PRINT

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
Born Country of Birth
 Refugee
Work Worksite
Occ. Occupation
Race
 White
 Black
 Asian
 Pacific Is.
 AI/AN
 Unknown
 Refused
 Other
Hispanic
 Yes
 No
 Unknown
 Declined
Subrace

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

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

Reporting
Reporter
Providers, Facilities & Labs
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

32

Record 1 of 1 (134,677 total)

Enter Pregnancy Status

Go to Zika Testing Questions

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

Suspect Case Example 2: Pregnant Woman with Ultrasound Findings

Jones, Marian DOB: 1/1/1980 Multnomah Zika

Search & Link Lab Report More Search for Patient in Orpheus Flagged for Review Note

ELR Person Info

Last: Jones
First: Marian
DOB: 1/1/1980
Sex: F M U
Race:
Hispanic:
Phone:

Orpheus Person Info

Jones
Marian
1/1/1980 36
 F M U
 White Asian AI/AN Refused
 Black Pacific Is. Unknown Other
Hispanic: Yes No Unknown

Person ID: 633804 Confidence: 100
Search Result: Case Created

ELR Lab Results

Specimen Date: 6/22/2016 Lag: 13 days
Specimen Source/Site: Other (please specify), Urine (3.4615384615384615)
Order: Arbovirus Triplex Panel, rRT-PCR

Test: MOL TITLE
Result: MOLECULAR TESTING
Test: MOL SRCE
Other (please specify), Urine
Test: MOL CHK FIN
Result: Test Not Performed
Test: MOL DEN FIN
Result: Test Not Performed
Test: MOL ZKA FIN
Result: Detected
Test: MOL COM
Result: The current Emergency Use

Set these fields before confirming link

Specimen Source: Other (please specify), Urine
Test Type: Arbovirus Triplex Panel, rRT-PCR
Result: MOLECULAR TESTING

If unable to confirm link with existing case:

Create Case for Jones, Marian
Break Link with Jones, Marian
Ignore Lab Report

Existing Case Records for Marian Jones

Disease	County	Onset	LHD Report	Created	Status	
Zika	Multnomah	06/20/16	07/08/16	07/08/16	C	Confirm Case Link View Case

**Test: MOL ZKA FIN
Result: Detected**

Confirm Case Link

Suspect Case Example 2: Pregnant Woman with Ultrasound Findings

New Case Investigation
HOME

Create a New Case Investigation
includes a check for duplicates

Disease: Zika Bug: Zika virus

Case Status: Suspect

Last Name: Jones

First Name: Rudolph

Middle:

DOB: 7/8/2016 This is today's date.
or age: 00

Sex: F M

Institution of residence: [Set]

Patient's Address: 800 NE Oregon

Zip Code: 97232

City, State: Portland OR

County: Multnomah

Clear Form Cancel Create Case

Create 'Suspect' case for neonate when baby is born

If test results come back negative and there are no physical findings, change case status to 'Under Investigation' for next year of follow-up

Suspect Case Example 3: Sexual Contact of Suspected Zika Case

- Enter case status as “Suspect” and create case
- Complete Pregnancy Status on case page
- Complete “Zika Testing” questions (red button on case page)
- Complete travel history and fill out pregnancy dates (LMM, EDD) *if applicable*
- **Link ELR to case and update case status**
- **If status is confirmed by test results, follow up with provider or case to ask questions on the Clinical Tab**

Confirmed Case Example 4: Positive ELR From Private Lab

- Link ELR to existing person or create new case
- Indicate Case Status is “Confirmed”
- Follow up with provider or case to ask questions on the Clinical Tab and to document pregnancy status and travel history

Unknown Case Status Example 5: Specimen Appears at OSPHL w/o Prior Approval

- ACDP will forward provider and patient information to LHD
- Contact provider to ask “Zika Testing” questions
- If patient meets criteria for testing, create a case in Orpheus; otherwise email ACDP to let us know
- Link ELR to case
- If case is confirmed, follow up with provider or case to ask questions on the Clinical Tab

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

PATIENT INFORMATION
Submitting facility: _____
Patient last name, first, middle initial: _____
Date of birth (mm/dd/yyyy): Female Male Patient ID/Chart number: _____
Ordering clinician: _____
Contact number: _____
Race: American Indian or Alaska Native Asian Hispanic or Latino Black or African American Native Hawaiian or Other Pacific Islander White Unknown Multi-race Other Unknown Declined 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: _____
Public Health Program eligible patient (for participating locations only)
 STD Program CCare Other: _____

PATIENT INSURANCE INFORMATION
Insurance/Health plan name: None Confidential
Policy no./Member ID: _____ Group ID: _____
Diagnosis/ICD-10 code for test: _____

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

TESTS REQUESTED

HEPATITIS	HIV
<input type="checkbox"/> HAVM: HEPATITIS A IGM ANTIBODY	<input type="checkbox"/> HIV: HIV-1/HIV-2 ANTIBODY SCREEN
<input type="checkbox"/> HAVT: HEPATITIS A TOTAL ANTIBODY	<input type="checkbox"/> CONFIRMATION OF PRELIMINARY POSITIVE RAPID TEST
<input type="checkbox"/> HBsAg: HEPATITIS B SURFACE ANTIGEN	<input type="checkbox"/> FOLLOW-UP OF INVALID RAPID TEST
<input type="checkbox"/> HBcT: HEPATITIS B CORE ANTIBODY	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> HBcM: HEPATITIS B CORE IGM ANTIBODY	Previous HIV testing (including rapid tests done today): _____

Oregon Form – Specimen Information for Lab Testing at the CDC 

- Required fields are marked with an asterisk (*). Failure to complete these fields will delay laboratory testing.
- Please contact the Oregon State Public Health Laboratory with questions at (503) 693-4100.

*Specimen Origin: Human Animal Food Environmental

*Lab Test Order Name: _____

*Suspected Agent / Organism: _____

*Patient Name: _____
Last First Middle Initial

*Sex: Male Female *Date of Birth: _____ Age: _____
MM/DD/YYYY Years

*Date of Illness Onset: _____ Is patient pregnant? Yes No N/A
MM/DD/YYYY (If yes, enter LMP or due date in Clinical History section; pg. 2)

*Patient ID: _____ Fatal: Yes No Date of Death: _____
MM/DD/YYYY

*Clinical Diagnosis: _____
Primary Symptom

*Specimen Collected: _____
MM/DD/YYYY Time AM / PM

*Material Submitted: Choose One *Specimen Source Type: _____
(e.g., blood, serum, CSF)

*Specimen Source Site: _____ Site Modifier: _____

Collection: _____
(e.g., biopsy, venipuncture) (e.g., centrifuge, extraction, culture)

SPECIMEN SUBMISSION

Specimen Submission

Number of Days between Symptom Onset and Specimen Collection	What to Collect
<14 days	2 mL of urine AND serum
14 days to 12 weeks	2 mL of urine AND serum*

*Collect 2ml serum only if the patient is symptomatic and is not pregnant.

Assist/Make sure appropriate submission of:

- Specimen(s)
 - Collect matched serum and urine specimens (collected on the same day). Other specimen sources may be requested based on patient case history and may require matched serum. 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

Specimen Submission Paperwork: Updates

Oregon Form – Specimen Information for Lab Testing at the CDC 

* Required fields are marked with an asterisk (*). Failure to complete these fields will delay laboratory testing.
* Please contact the Oregon State Public Health Laboratory with questions at (503) 693-4100.

*Specimen Origin: Human Animal Food Environmental

*Lab Test Order Name:

*Suspected Agent / Organism:

*Patient Name:

*Sex: Last First Middle Initial

*Date of Birth: MM/DD/YYYY Age: Years

*Date of Illness Onset: MM/DD/YYYY Is patient pregnant? Yes No N/A
(If yes, enter LMP or due date in Clinical History section, pg. 2)

*Patient ID: Fatal: Yes No Date of Death: MM/DD/YYYY

*Clinical Diagnosis:
Primary Symptom

*Specimen Collected: MM/DD/YYYY Time AM / PM

*Material Submitted: Choose One *Specimen Source Type: (e.g., blood, serum, CSF)

*Specimen Source Site: (anatomical site of collection) Site Modifier: (e.g., anterior, upper, superficial)

Collection Method: (e.g., biopsy, venipuncture) Treatment of Specimen: (e.g., centrifuge, extraction, culture)

Transport medium/Preservative: Specimen Handling: (refrigerated, frozen, ambient, etc.)

*Ordering Clinician:

*Submitting Facility Name:

*Submitting Facility:

Street City State Zip

Phone Number Fax Number (HIPAA Secure)

Contact Person Name (for questions about this order) Direct Phone Number

v. 2016-03 Page 1 of 2

- OSPHL virology form
 - No changes to form
 - Available in most clinical labs or call OSPHL Virology/Immunology
- New version of the CDC form
 - Now includes pregnancy status
 - Completing travel history is required for Zika testing.
 - Available at bitly.com/OR-CDC-Testing

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"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <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

VIROLOGY/IMMUNOLOGY REQUEST
Oregon State Public Health Laboratory
P.O. Box 275, Portland, OR 97207-0275
Information: 503-893-4100

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 Hispanic or Latino Native Hawaiian or Other Pacific Islander White Multi-race Other Unknown Declined

Ethnicity: 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: Home Commercial

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: 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 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) Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

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 info

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: _____
Public Health Program eligible patient: (for participating locations only) Yes No

PATIENT INSURANCE INFORMATION
Insurance/Health plan name: None Confidential
Policy no./Member ID: _____ Group ID: _____
Diagnosis/ICD-10 code for test: _____

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

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/CC: CHLAMYDIA/GONORRHEA BY NAAT (Note: Add 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-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

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) 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL Virology/Immunology form

SPECIMEN INFORMATION	
Specimen source: <input type="checkbox"/> Blood <input type="checkbox"/> Oral Fluid <input type="checkbox"/> NP <input type="checkbox"/> Swab <input type="checkbox"/> Stool <input type="checkbox"/> Serum <input type="checkbox"/> Other: _____	Illness onset (mm/dd/yyyy):

OSPHL Virology/Immunology form

Pregnancy Status

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 CCare Other: _____

SPECIMEN INFORMATION

Specimen source: _____ 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/CC: CHLAMYDIA/GONORRHEA BY NAAT (Note: Add 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-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 UVD: 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) JBB

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
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 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: _____

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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.)

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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:
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Month of last test: _____ Year: _____

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BRU TOT: BRUCELLA RUB: RUBELLA IgG
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 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: _____

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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
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 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: _____

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OSPHL Virology/Immunology form

VIROLOGY/IMMUNOLOGY REQUEST
Oregon State Public Health Laboratory
P.O. Box 275, Portland, OR 97207-0275
Information: 503.683.4400

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 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: _____
Diagnosis/ICD-10 code: _____
Public Health Program eligible patient: (for participating locations only) _____

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
 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) 1750408159 Laboratory Director: John L. Fontana, PhD, (HCLD) ABB

OSPHL UPDATES

Testing menu and changes to website

Chikungunya Virus	
Updated	7/30/2014
Other Names	
How to Order	Check the "Other" box Under the Miscellaneous Serology heading on the Virology/Immunology Request form (form 42) and write in Chikungunya
Availability	All clients with prior approval from the Acute and Communicable Disease and Epidemiology Program
Methodology	Enzyme-Linked Immunosorbent Assay (ELISA), Virus Isolation, Nucleic Acid Amplification Testing (NAAT)
Performed	Referred to Reference laboratory for testing on day of receipt
Time to Reporting	4-21 days after receipt of specimen
CPT Code	
Specimen Collection Details	
Collection	Whole blood in a Serum Separator tube is preferred. If a red-top is used, the serum must be separated off into a clean tube after the specimen clots. Fresh frozen tissue Cerebrospinal fluid
Optimal Volume	
Minimum Volume	Serum: 0.5 mL CSF: 1.0 mL Tissue: 1 cm3
Handling	Serum and CSF: Refrigerate or freeze. Maintain temperature during shipping. Tissue for virus isolation and NAAT: freeze at -70°C as soon as possible and ship on dry ice so samples remain frozen
Transport	Refrigerated, or frozen on dry ice.
Rejection Criteria	Formalin fixed tissues. Whole blood.
Comments	

- OSHPL is updating the Lab Test Menu to support proper specimen collection, storage, and transport. (www.healthoregon.org/labtests)
- OSPHL websites will be updated to reflect recent changes

Lab Test Menu for both Zika tests will follow this format.
Note: These are not the instructions for Zika virus testing.