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
☐ 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: _____

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/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

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 rest result was:
☐ NEG ☐ POS ☐ Prelim Pos ☐ Indeterminate ☐ Unknown

Month of last test: _____ Year: _____

MISCELLANEOUS SEROLOGY

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

COMMENTS

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