New York State Department of Health
Wadsworth Center
Empire State Plaza
PO Box 509, Albany, NY 12201-0509

Infectious Diseases Requisition

NYS Accession Number ____________________

Date received _____ / _____ / _____

Shipping address: www.wadsworth.org/wcinfo.htm

Telephone: (518) 474-4177

Patient Demographics

*denotes required information

Last Name * ____ First Name * ____ MI ____ DOB * ___ / ___ / ___ Sex ☐ Male ☐ Female

Street Address ____ City ____ State ____ Zip Code ____

NYS County of Residence * ____ NYS DOH Outbreak Number ____ CDESS Case Number ____ Submitter's Reference Number ____

Submitter (Laboratory report will be sent to)

*denotes required information

Name and Address *

Referral Lab
New York Presbyterian Hospital
622 West 168th Street
PH 3W, Room 355
New York, NY 10032
Phone: 212-305-6245
Fax: 212-342-3544

Laboratory PFI 5310

Contact Person ____

Telephone Number (____) ____ - ____

Specimen Information

*denotes required information

Specimen is: ☐ Isolate ☐ Primary Specimen ☐ Autopsy Specimen

Collection Date * ___ / ___ / ___ (MM DD YYYY)

Source / Specimen Type * ____

Time Collected (if applicable for test) ___ : ___ (HH : MM)

Laboratory Examination Requested

www.wadsworth.org/IDtesting

☐ **Bacterial** ☐ **Fungal** ☐ **Mycobacterial** ☐ **Parasitic** ☐ **Serology** ☐ **Viral**

Suspected Organism / Agent ____

☐ **Identification / Confirmation**

☐ **TB Fast Track** www.wadsworth.org/mycobac/fasttrack.htm

☐ **Viral Encephalitis Panel** www.wadsworth.org/divisions/infdis/enceph/form.htm

☐ **Susceptibility (specify antimicrobial(s))** ____

☐ **Serology (specify test and define onset date)** ____

☐ **Other (specify)** ____

Submitting lab findings: Smear/Stain/Other results ____ Comments ____

Specimen submitted on/in: Media ____ Preservative ____ Tissue cell line ____

Relevant Exposure: ☐ Contact known case ☐ Food/water ☐ Nosocomial

☐ Travel ____ (Location & Dates) ☐ Animal ____ (Type) ☐ Arthropod ____ (Type)

Clinical History

Name of patient's healthcare provider ____ Telephone Number (____) ____ - ____

Diagnosis: ____ Hospitalized? ☐ Yes ☐ No ☐ Unknown If hospitalized, hospital name: ____

Pregnant (trimester): ____ Symptoms: ☐ Acute ☐ Chronic ☐ Other ____ Onset of symptoms: ___ / ___ / ___ (MM DD YYYY)

Fever: max ____ duration ____ CSF: Glu ____ Prot ____ RBC ____ WBC ____

Relevant Treatment: ____ Date ___ / ___ / ___ Relevant Immunization: ____ Date ___ / ___ / ___

Symptoms/Clinical Epidemiology (check all that apply):

Central Nervous System: ☐ Altered Mental Status ☐ Coma ☐ Encephalitis ☐ Headache ☐ Meningitis ☐ Paralysis ☐ Seizures

Gastrointestinal: ☐ Diarrhea ☐ Blood/Mucus ☐ Nausea ☐ Vomiting

Respiratory: ☐ Bronchitis ☐ Bronchiolitis ☐ Cough ☐ Pneumonia ☐ Upper Respiratory Infection

Skin/hair/nails: ☐ Hemorrhagic ☐ Maculopapular Rash ☐ Petechial Rash ☐ Vesicular

Cardiovascular: ☐ Endocarditis ☐ Myocarditis ☐ Pericarditis

Miscellaneous: ☐ Arthralgia ☐ Conjunctivitis ☐ Cystitis ☐ Hepatitis ☐ Hepatomegaly ☐ Immunocompromised ☐ Jaundice ☐ Keratitis ☐ Lymphadenopathy ☐ Malaise ☐ Myalgia ☐ Pleurodynia ☐ Splenomegaly ☐ Ulcer(s) ☐ Urethritis

Other Symptoms: ____