



OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 205-8917 | FX (304) 558-0895

PLACE BARCODE HERE

OLS USE ONLY

BIOterrorism Clinical Sample Submission Form

INSTRUCTIONS: Specimens submitted for testing **MUST** include this fully completed submission form. Use one form per source. Use this form only for samples submitted to the Threat-Preparedness & Bioterrorism Response Section (BT Lab) for identifying potential Bioterrorism Agents. You **MUST** receive verbal authorization from the BT Lab prior to sending any specimens. Notify your local health department. Please type answers.

PATIENT INFORMATION

PATIENT ID (Chart #, etc.)		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH		AGE
COUNTY OF RESIDENCE	RACE & ETHNICITY <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/ Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> non-Hispanic	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Ambiguous <input type="checkbox"/> Other
STREET ADDRESS		
CITY	STATE	ZIP
PARENT OR GUARDIAN NAME (if applicable)		

SUSPECTED ORGANISM(S)

☐ Bacillus anthracis ☐ Brucella spp. ☐ Burkholderia spp.
☐ Francisella tularensis ☐ Mpox ☐ Ricin ☐ Yersinia pestis
☐ Influenza AH5/H7 ☐ Other _____

SPECIMEN INFORMATION

Type: <input type="checkbox"/> Serum <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Isolate <input type="checkbox"/> Other _____	Source: <input type="checkbox"/> Wound <input type="checkbox"/> Bite <input type="checkbox"/> Venipuncture <input type="checkbox"/> Other _____	Submitted on (specify media):
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DATE OF COLLECTION (mm/dd/yyyy):

TIME OF COLLECTION:

SENTINEL LEVEL TESTS PERFORMED & GROWTH RESULTS

<input type="checkbox"/> Catalase <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> BAP <input type="checkbox"/> Growth <input type="checkbox"/> No	GRAM STAIN: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Bacilli <input type="checkbox"/> Cocci <input type="checkbox"/> Coccobacilli
<input type="checkbox"/> Oxidase <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> MAC <input type="checkbox"/> Growth <input type="checkbox"/> No	
<input type="checkbox"/> Urease <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> CHOC <input type="checkbox"/> Growth <input type="checkbox"/> No	
<input type="checkbox"/> Indole <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> _____ <input type="checkbox"/> Growth <input type="checkbox"/> No	
<input type="checkbox"/> Motility <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Hemolysis <input type="checkbox"/> Yes <input type="checkbox"/> No	

SUBMITTER INFORMATION

SUBMITTER AGENCY		
SUBMITTER NAME & TITLE		
STREET ADDRESS		
CITY	STATE	ZIP
COUNTY	EMAIL	
PHONE NO.	FAX NO.	
NAME OF PERSON WHO SHOULD RECEIVE REPORT AT FACILITY		

EPIDEMIOLOGIC INFORMATION

☐ Single Case ☐ Sporadic ☐ Epidemic ☐ Other _____

DATE OF SYMPTOM ONSET (mm/dd/yyyy):

CLINICAL SYMPTOMS:

PATIENT EMPLOYMENT/TRADE:

RECENT TRAVEL (Location & Date):

Is patient using Antibiotics?
☐ Yes ☐ No

Antibiotic used: _____
Start date: _____
Duration: _____

Contact with ill or deceased animal or arthropod?
☐ Yes ☐ No
Date: _____

☐ Swine ☐ Cattle
☐ Rabbits ☐ Poultry
☐ Tick ☐ Mosquito
☐ Other _____

Location: _____

Contact with other people with similar symptoms?
☐ Yes ☐ No
Date: _____

Describe Animal's Illness: _____
Describe Contact's Illness: _____

MANDATORY PRIOR NOTIFICATION INFORMATION

LOCAL HEALTH DEPT. (COUNTY)	CONTACT NAME	DATE & TIME
DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY (DIDE)	CONTACT NAME	DATE & TIME
OFFICE OF LAB SERVICES (OLS) BT LAB	CONTACT NAME	DATE & TIME
OTHER AGENCIES CONTACTED	CONTACT NAME	DATE & TIME

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DATE & TIME RECEIVED	NOTES	TECH INITIALS
DATE & TIME REPORTED	RESULTS REPORTED TO	TECH INITIALS

Signature _____ Date _____