



PLACE BARCODE HERE

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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"/> Not specified
STREET ADDRESS		
CITY	STATE	ZIP
PARENT OR GUARDIAN NAME (if applicable)		

SUSPECTED ORGANISM(S)

<input type="checkbox"/> Bacillus anthracis <input type="checkbox"/> Brucella spp. <input type="checkbox"/> Burkholderia spp. <input type="checkbox"/> Francisella tularensis <input type="checkbox"/> Mpox <input type="checkbox"/> Ricin <input type="checkbox"/> Yersinia pestis <input type="checkbox"/> Influenza AH5/H7 <input type="checkbox"/> Other _____
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SPECIMEN INFORMATION

Type (specimen submitted): <input type="checkbox"/> Serum <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Isolate <input type="checkbox"/> OP <input type="checkbox"/> NP <input type="checkbox"/> Other _____	Source (original site of collection): <input type="checkbox"/> Blood <input type="checkbox"/> Wound <input type="checkbox"/> Bite <input type="checkbox"/> Upper Respiratory <input type="checkbox"/> Lower Respiratory <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 PERSONS TO RECEIVE REPORT AT FACILITY (LIST 2 OR MORE):		

EPIDEMIOLOGIC INFORMATION

<input type="checkbox"/> Single Case <input type="checkbox"/> Sporadic <input type="checkbox"/> Epidemic <input type="checkbox"/> Other _____

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

CLINICAL SYMPTOMS:

PATIENT EMPLOYMENT/TRADE:

RECENT TRAVEL (Location & Date):

Is patient using Antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotic used: _____ Start date: _____ Duration: _____
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Contact with ill or deceased animal or arthropod? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Swine <input type="checkbox"/> Cattle <input type="checkbox"/> Rabbits <input type="checkbox"/> Poultry <input type="checkbox"/> Tick <input type="checkbox"/> Mosquito <input type="checkbox"/> Other _____	Describe Animal's Illness :
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Contact with other people with similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Describe Contact's Illness:
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MANDATORY PRIOR NOTIFICATION INFORMATION

LOCAL HEALTH DEPT.	CONTACT NAME	DATE & TIME
OFFICE OF EPIDEMIOLOGY & PREVENTION SERVICES (OEPS)	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 _____