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 specimen. 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 q American Indian q Asian q Black q Hawaiian/ Pacific Islander q White q Hispanic q non-Hispanic	SEX q Female q Male q Transgender q Ambiguous q Other	
STREET ADDRESS			
CITY	STATE	ZIP	
PARENT OR GUARDIAN NAME (if applicable)			

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		

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

SUSPECTED ORGANISM(S)

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

SPECIMEN INFORMATION

Type: q Serum q Blood q Sputum q Isolate q Other_____	Source: q Wound q Bite q Venipuncture q Other _____	Submitted on (specify media):
DATE OF COLLECTION (mm/dd/yyyy): TIME OF COLLECTION:		

SENTINEL LEVEL TESTS PERFORMED & GROWTH RESULTS

q Catalase	q Pos	q Neg	q BAP	q Growth	q No	GRAM STAIN:	
q Oxidase	q Pos	q Neg	q MAC	q Growth	q No	q Pos	q Neg
q Urease	q Pos	q Neg	q CHOC	q Growth	q No	q Bacilli	
q Indole	q Pos	q Neg	q _____	q Growth	q No	q Cocci	
q Motility	q Pos	q No	q Hemolysis	q Yes	q No	q Coccobacilli	

EPIDEMIOLOGIC INFORMATION

q Single Case q Sporadic q Epidemic q Other_____

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

CLINICAL SYMPTOMS:

PATIENT EMPLOYMENT/TRADE:

RECENT TRAVEL (Location & Date):

Is patient using Antibiotics? q Yes q No	Antibiotic used: _____ Start date:_____ Duration:_____	
Contact with ill or deceased animal or arthropod? q Yes q No Date:	q Swine q Cattle q Rabbits q Poultry q Tick q Mosquito q Other _____	Location:
	Describe Animal's Illness:	
Contact with other people with similar symptoms? q Yes q No Date:	Describe Contact's Illness:	

_____
Signature Date

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS **REV. 04/25**