OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

ARBOVIRUS LABORATORY HUMAN SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *MAX. 17 CHARACTERS*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	AGE	SS# *(last 4 only, optional)*
COUNTY OF RESIDENCE		SEX ❑ Female ❑ Male
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. *(optional)*		

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO.		
FAX NO.		

COMMENTS:

OLS USE ONLY	
❑ UNSAT | Reason: ❑ SATISFACTORY	ACC: DE: CKD:

DATE OF COLLECTION:

SOURCE OF SPECIMEN:	
❑ Serum (acute)***	❑ CSF***
❑ Serum (convalescent)***	❑ Other _____
*** minimum of one milliliter (1mL) serum and CSF	

TEST REQUESTED:	
❑ Arbovirus Panel	❑ Confirmation
Suspected Virus:	

REQUIRED INFORMATION:

Date of Symptom Onset:

SYMPTOMS: (must include temperature reading for any fever occurrence)

❑ Fever (°F) -or- (°C)	
❑ Myalgia / Arthralgia	❑ Acute flaccid paralysis (AFP)
❑ Headache	❑ Altered mental status
❑ Meningitis / Encephalitis	❑ Rash
❑ Other _____	

TRAVEL HISTORY:

Has patient traveled outside of **WV** within the past four (4) weeks?

❑ Yes ❑ No ❑ Unknown

Location: Dates:

Has patient traveled outside the **US** within the past four (4) weeks?

❑ Yes ❑ No ❑ Unknown

Location: Dates:

VACCINATION HISTORY:

❑ Yellow Fever	❑ Tick-borne Encephalitis
❑ Japanese Encephalitis	❑ Unknown

VECTOR CONTACT:

❑ Mosquito	❑ Tick
❑ None	❑ Unknown

DIDE CASE NO.:

ALL ABOVE HUMAN CASE INFORMATION MUST BE PROVIDED

FAILURE TO COMPLETE WILL RESULT IN REJECTION OF SAMPLE FOR TESTING