Oregon Form – Specimen Information for Lab Testing at the CDC

- Required fields are marked with an asterisk (*). Failure to complete these fields will delay laboratory testing.
- Please contact the Oregon State Public Health Laboratory with questions at (503) 693-4100.

***Specimen Origin:** ☐ Human ☐ Animal ☐ Food ☐ Environmental

***Lab Test Order Name:**

***Suspected Agent / Organism:**

***Patient Name:**
Last First Middle Initial

***Sex:** ***Date of Birth:** MM/DD/YYYY **Age:** Years

***Date of Illness Onset:** MM/DD/YYYY **Is patient pregnant?** ☐ Yes ☐ No ☐ N/A
(If yes, enter LMP or due date in Clinical History section; pg. 2)

***Patient ID:** **Fatal:** ☐ **Yes** ☐ **No** **Date of Death:** MM/DD/YYYY

***Clinical Diagnosis:**
Primary Symptom

***Specimen Collected:** MM/DD/YYYY Time **AM / PM**

***Material Submitted:** Choose One ***Specimen Source Type:**
(e.g., blood, serum, CSF)

***Specimen Source Site:**
(anatomical site of collection)
Site Modifier:
(e.g., anterior, upper, superficial)

Collection Method:
(e.g., biopsy, venipuncture)
Treatment of Specimen:
(e.g., centrifuge, extraction, culture)

Transport medium/ Preservative:
Specimen Handling:
(refrigerated, frozen, ambient, etc.)

***Ordering Clinician:**
Last First Credentials/License

***Submitting Facility Name:**

***Submitting Facility:**
Street City State Zip

Phone Number Fax Number (HIPAA Secure)

Contact Person Name (for questions about this order) Direct Phone Number

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***Patient Name:**

Last First Middle Initial

Brief Clinical History:
(e.g., signs, symptoms, underlying illnesses, if known.)

State of Illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Acute
- ☐ Chronic
- ☐ Convalescent
- ☐ Recovered

Type of Infection:
- ☐ Upper respiratory
- ☐ Lower respiratory
- ☐ Cardiovascular
- ☐ Gastrointestinal
- ☐ Genital
- ☐ Urinary tract
- ☐ Other, specify:
- ☐ Sepsis
- ☐ Central nervous system
- ☐ Skin/soft tissue
- ☐ Ocular
- ☐ Joint/bone
- ☐ Disseminated

Therapeutic Agent(s) During Illness

	Agent	Start Date MM/DD/YYYY	End Date MM/DD/YYYY
1.			
2.			
3.			

Epidemiological Data

Extent
- ☐ Isolated Case
- ☐ Carrier
- ☐ Contact
- ☐ Outbreak — Outbreak Number
  - ☐ Family
  - ☐ Community
  - ☐ Healthcare-associated
  - ☐ Epidemic

Travel History *(Note: This section is required for arbovirus testing.)*

Is there pertinent travel history? ☐ Yes ☐ No **If yes, complete:**

Dates of Travel: to (MM/DD/YYYY)

Travel: Foreign (countries):

Travel: United States (states)

Foreign Residence (country):

United States Residence (state)

If additional countries or states need to be entered, include in the Brief Clinical History field.

Exposure History

Is there a relevant exposure? ☐ Yes ☐ No

If yes:

☐ Animal *Type of Exposure:* Choose One

Common Name:

Scientific Name:

☐ Arthropod *Type of Exposure:* Choose One

Common Name:

Scientific Name:

Relevant Immunization History

	Vaccination	Date Received MM/DD/YYYY
1.		
2.		
3.		

Previous Laboratory Results / Comments (or attach copy of test results or worksheet)