Reset Form

Print Form

Poxvirus Human Specimen Submission Form

Ship specimens to:
Centers for Disease Control and Prevention
ATTN: STAT Laboratory / Poxvirus Program
1600 Clifton Road NE, MS G-12
Atlanta, Georgia 30333
Phone: 404.639.4129 Fax: 404.639.1060

CASE NUMBER *(Poxvirus lab only):*

DATE RECEIVED:

Consultation with your state communicable disease unit / health laboratory is necessary BEFORE submission of specimens to CDC. Visit www.cste.org and www.aphl.org for listings of state epidemiologists and state laboratories.

Please remit one copy of the form with shipment of specimens.

FORM COMPLETED BY: _____ **DATE FORM COMPLETED:** _____ *(mm/dd/yyyy)*

PROVIDER *(Submitted by)*:	**INVESTIGATOR *(State contact)*:**
NAME:	**NAME:**
ORGANIZATION:	**ORGANIZATION:**
ADDRESS:	**ADDRESS:**
CITY, STATE:	**CITY, STATE:**
ZIP CODE: **COUNTRY:**	**ZIP CODE:** **COUNTRY:**
TELEPHONE 1: **FAX:**	**TELEPHONE 1:** **FAX:**
EMAIL:	**EMAIL:**

AGENT BEING TESTED FOR:

- ☐ ORTHOPOXVIRUS
  - ☐ COWPOX
  - ☐ MONKEYPOX
  - ☐ VACCINIA
  - ☐ VARIOLA
- ☐ PARAPOXVIRUS
  - ☐ BPSV
  - ☐ ORF
  - ☐ PSUEDOCOWPOX
  - ☐ SEALPOX
- ☐ TANAPOX
- ☐ OTHER POXVIRUS: _____
- ☐ HERPES VIRUS
  - ☐ VARICELLA
  - ☐ HSV-1 or HSV-2
- ☐ OTHER, SPECIFY: _____

Testing for herpes viruses is performed by the Measles, Mumps, Rubella, and Herpes Viruses Branch.
Testing for poxviruses in formalin fixed or paraffin embedded specimens is performed by the Infectious Disease Pathology Branch.
Serum must be submitted with cerebral spinal fluid when testing for post-vaccinial meningitis or encephalitis.

1. PATIENT NAME: _____ *Last, First MI*

2. DATE OF BIRTH: _____ *(mm/dd/yyyy)*

3. AGE *(if DOB unk)*:

4. SEX: ☐ Female ☐ Male ☐ Unknown

5. DATE IDENTIFIED: _____ *(mm/dd/yyyy)*

6. STATE ID NUMBER:

7. CITY, STATE:

8. ZIP CODE:

9. COUNTY:

10. COUNTRY (IF NOT USA):

11. HAS THIS PATIENT BEEN HOSPITALIZED BECAUSE OF ILLNESS? ☐ Yes ☐ No ☐ Unknown

Hospital ID number: _____

12. WHAT WAS THE CLINICAL OUTCOME FOR THIS PATIENT? ☐ Recovering ☐ Recovered ☐ Died ☐ Unknown

Date of death: _____ *(mm/dd/yyyy)*

13. DID THIS PATIENT EXPERIENCE A FEVER AS PART OF THEIR ILLNESS? ☐ Yes ☐ No ☐ Unknown

Fever onset date: _____ *(mm/dd/yyyy)*

Last modified: April 2011

14. DID THE PATIENT EXPERIENCE A RASH AS PART OF THEIR ILLNESS? ☐ Yes ☐ No ☐ Unknown

Rash onset date: _____ *(mm/dd/yyyy)*

RASH TYPE:

☐ MACULES *(discolored and flat)*	APPROX # _____	LOCATION	_____
☐ PAPULES *(discolored and raised)*	APPROX # _____	LOCATION	_____
☐ VESICLES *(raised and fluid filled)*	APPROX # _____	LOCATION	_____
☐ PUSTULES *(raised and pus filled)*	APPROX # _____	LOCATION	_____
☐ OTHER *(eschar, nodule, etc.)* _____	APPROX # _____	LOCATION	_____

15. HAS THIS PATIENT TRAVELED INTERNATIONALLY WITHIN ONE MONTH PRIOR TO ILLNESS ONSET?

☐ Yes ☐ No ☐ Unknown If yes, where: _____

16. HAS THIS PATIENT BEEN IN CONTACT WITH PERSON(S) RECENTLY VACCINATED AGAINST SMALLPOX?

☐ Yes ☐ No ☐ Unknown If yes, with who: _____

17. HAS THIS PATIENT BEEN IN CONTACT WITH ANIMAL(S) WITHIN ONE MONTH PRIOR TO ILLNESS ONSET?

☐ Yes ☐ No ☐ Unknown If yes, with what animals and where: _____

18. DOES THIS PATIENT WORK WITH POXVIRUSES IN A LABORATORY SETTING?

☐ Yes ☐ No ☐ Unknown If yes, what strain(s): _____

19. HAS THE PATIENT EVER BEEN VACCINATED WITH THE SMALLPOX VACCINE (VACCINIA VIRUS)? ☐ Yes ☐ No ☐ Unknown

20. IF YES, LIST DATES *(if exact date unknown indicate year)*:

Date: _____ *(mm/dd/yyyy)*	Date: _____ *(mm/dd/yyyy)*	Date: _____ *(mm/dd/yyyy)*
Year: _____	Year: _____	Year: _____

21. DOES THIS PATIENT HAVE A SCAR FROM SMALLPOX VACCINATION? ☐ Yes ☐ No ☐ Unknown

22. HAS THIS PATIENT EVER BEEN INFECTED WITH SMALLPOX? ☐ Yes ☐ No ☐ Unknown

23. HAS THIS PATIENT BEEN RECENTLY EXPOSED TO SMALLPOX? ☐ Yes ☐ No ☐ Unknown

24. DOES THIS PATIENT HAVE A PREVIOUS HISTORY OF CHICKENPOX? ☐ Yes ☐ No ☐ Unknown

25. WAS THIS PATIENT EVER PREVIOUSLY VACCINATED AGAINST CHICKENPOX? ☐ Yes ☐ No ☐ Unknown

26. HAS THIS PATIENT BEEN RECENTLY EXPOSOSED TO CHICKENPOX? ☐ Yes ☐ No ☐ Unknown

27. HAS THIS PATIENT TAKEN ANY STEROIDS / IMMUNOSUPPRESSANT DRUGS ONE MONTH PRIOR TO RASH ONSET? ☐ Yes ☐ No ☐ Unknown

28. PLEASE NOTE ANY ADDITIONAL CLINICAL OBSERVATIONS OR MEDICAL HISTORY NOT PREVIOUSLY COVERED.

PLEASE COMPLETE ONE SPECIMEN SECTION PER SPECIMEN SUBMITTED
(E.G., IF THREE SPECIMENS ARE SUBMITTED THEN THREE SPECIMEN SECTIONS SHOULD BE COMPLETED)

SPECIMEN SECTION 1 **DATE SPECIMEN COLLECTED:** _____ *(mm/dd/yyyy)*

SPECIMEN MATERIAL:		**COLLECTION METHOD:**		**DASH NUMBER:**
☐ BLOOD	☐ PUSTULE SKIN	☐ SWAB	☐ EM GRID	
☐ SERUM	☐ PUSTULE FLUID	☐ SLIDE *(touch prep, smear, etc.)*	☐ SLIDE *(formalin fixed)*	
☐ PLASMA	☐ VESICLE SKIN	☐ FRESH FROZEN TISSUE	☐ FORMALIN FIXED TISSUE	
☐ CSF	☐ VESICLE FLUID	☐ CONTAINER	☐ PARAFFIN BLOCK	
☐ CRUST	☐ BIOPSY	☐ BLOOD TUBE TYPE *(blue, red marble, pink, etc.)* _____		
☐ OTHER _____		☐ OTHER COLLECTION TYPE _____		

ADDITIONAL SPECIMEN INFORMATION: _____

SPECIMEN SECTION 2 **DATE SPECIMEN COLLECTED:** _____ *(mm/dd/yyyy)*

SPECIMEN MATERIAL:		**COLLECTION METHOD:**		**DASH NUMBER:**
☐ BLOOD	☐ PUSTULE SKIN	☐ SWAB	☐ EM GRID	
☐ SERUM	☐ PUSTULE FLUID	☐ SLIDE *(touch prep, smear, etc.)*	☐ SLIDE *(formalin fixed)*	
☐ PLASMA	☐ VESICLE SKIN	☐ FRESH FROZEN TISSUE	☐ FORMALIN FIXED TISSUE	
☐ CSF	☐ VESICLE FLUID	☐ CONTAINER	☐ PARAFFIN BLOCK	
☐ CRUST	☐ BIOPSY	☐ BLOOD TUBE TYPE *(blue, red marble, pink, etc.)* _____		
☐ OTHER _____		☐ OTHER COLLECTION TYPE _____		

ADDITIONAL SPECIMEN INFORMATION: _____

SPECIMEN SECTION 3 **DATE SPECIMEN COLLECTED:** _____ *(mm/dd/yyyy)*

SPECIMEN MATERIAL:		**COLLECTION METHOD:**		**DASH NUMBER:**
☐ BLOOD	☐ PUSTULE SKIN	☐ SWAB	☐ EM GRID	
☐ SERUM	☐ PUSTULE FLUID	☐ SLIDE *(touch prep, smear, etc.)*	☐ SLIDE *(formalin fixed)*	
☐ PLASMA	☐ VESICLE SKIN	☐ FRESH FROZEN TISSUE	☐ FORMALIN FIXED TISSUE	
☐ CSF	☐ VESICLE FLUID	☐ CONTAINER	☐ PARAFFIN BLOCK	
☐ CRUST	☐ BIOPSY	☐ BLOOD TUBE TYPE *(blue, red marble, pink, etc.)* _____		
☐ OTHER _____		☐ OTHER COLLECTION TYPE _____		

ADDITIONAL SPECIMEN INFORMATION: _____

SPECIMEN SECTION 4 **DATE SPECIMEN COLLECTED:** _____ *(mm/dd/yyyy)*

SPECIMEN MATERIAL:		**COLLECTION METHOD:**		**DASH NUMBER:**
☐ BLOOD	☐ PUSTULE SKIN	☐ SWAB	☐ EM GRID	
☐ SERUM	☐ PUSTULE FLUID	☐ SLIDE *(touch prep, smear, etc.)*	☐ SLIDE *(formalin fixed)*	
☐ PLASMA	☐ VESICLE SKIN	☐ FRESH FROZEN TISSUE	☐ FORMALIN FIXED TISSUE	
☐ CSF	☐ VESICLE FLUID	☐ CONTAINER	☐ PARAFFIN BLOCK	
☐ CRUST	☐ BIOPSY	☐ BLOOD TUBE TYPE *(blue, red marble, pink, etc.)* _____		
☐ OTHER _____		☐ OTHER COLLECTION TYPE _____		

ADDITIONAL SPECIMEN INFORMATION: _____