NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Infectious Diseases Requisition

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
Postal Address: David Axelrod Institute, PO Box 22002, Albany, NY 12201
Courier Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: Courier Address: 5668 State Farm Rd, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to: https://www.wadsworth.org/programs/id

Patient Demographics and Requesting Provider

*required information

Last name* | First name* | MI | DOB* / / | ☐ Male ☐ Other ☐ Female

Permanent Street Address | Facility of Residence (if applicable) | City | State | Zip Code

NYS County of Residence* | Patient Reference Number | NYS DOH Outbreak Number | CDESS Case Number

Name and National Provider Identifier (NPI) for Health Care Provider: | Phone:

Submitting Facility (Laboratory report will be sent to this address)

*required information

Name* | Laboratory PFI

Address* | NPI

Contact Person* | Phone* Ext

Specimen Information

*required information

Collection Date*: / / | Time Collected (if applicable): | Date of Symptoms Onset: / / | ☐ Autopsy

Source(s)*	Specimen submitted on/in (specify media/preservative/cell line)		Submitter's Specimen Identifier(s)
		☐ Isolate ☐ Primary	
		☐ Isolate ☐ Primary	
		☐ Isolate ☐ Primary	

Laboratory Examination Requested

☐ Confirmation ☐ Identification/Detection Submitter Lab Findings: Smear/Stain/Other:

Suspect Organism/Agent

☐ **Bacterial** _____
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other Susceptibility (please specify): _____

☐ **Fungal** _____
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility Other
- ☐ Antifungal Susceptibility

☐ **Mycobacterial** _____

Suspect Organism/Agent

☐ **Parasitic** _____
- ☐ Malaria Drug Susceptibility

☐ **Serology** _____

☐ **Viral**** _____
- ☐ Viral Encephalitis PCR Panel on CSF
- ☐ Influenza Antiviral Susceptibility

☐ **Other** _____

Clinical History

Relevant Exposure: ☐ Travel ☐ Animal ☐ Arthropod ☐ Contact w/ Known Case ☐ Food/Water

Exposure Detail: | Hospitalized: ☐ Yes ☐ No | Hospital Name:

Diagnosis: | Pregnant (trimester): | Fever (max): | CSF: Glu ____ Prot ____ RBC ____ WBC ____

Relevant Treatment: | Date: / / | Relevant Immunization: | Date: / /

Symptoms (check all applicable): ☐ Acute ☐ Chronic ☐ Other Symptoms _____

Cardiovascular	Central Nervous System	Rash	Respiratory	Miscellaneous	
☐ Endocarditis	☐ Altered Mental Status	☐ Hemorrhagic	☐ Bronchitis	☐ Arthralgia	☐ Lymphadenopathy
☐ Myocarditis	☐ Encephalitis	☐ Maculopapular	☐ Cough	☐ Conjunctivitis	☐ Malaise
☐ Pericarditis	☐ Headache	☐ Petechial	☐ Pneumonia	☐ Hepatitis	☐ Myalgia
	☐ Meningitis	☐ Vesicular	☐ Upper Respiratory	☐ Hepatomegaly	☐ Splenomegaly
	☐ Paralysis			☐ Immunocompromised	

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Non-Human Samples

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Submitter (test ordered by)

*required information

Name*:

Address*:

Contact Person*: Phone*: Ext

Sample Information

Collection Date*: / / Rabies Lab Only Second Collection Date: / /

NYSDOH Outbreak Number:

Collection Site:

Street Address:

City: State: Zip Code: NYS County:

Laboratory Examination Requested

☐ Bacterial ☐ Fungal ☐ Mycobacterial ☐ Parasitic ☐ Serology ☐ Viral ☐ Other

Suspect Organism/Agent:

Animal

☐ Domestic ☐ Wild

☐ Avian ☐ Mammal ☐ Reptile ☐ Other

Common Name or Species:

Submitter Sample Number: Sample Source:

Domestic Animal Owner Name: Animal Name:

Comments:

Food

Brand Name:

Lot Number: USDA Number: Sell By Date: / /

Sample Description:

Comments:

Environmental

Source Description:

Describe below samples taken; use separate sheets if necessary.

Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)	Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)

Comments: